DOCUMENT RESUME

ED 032 676 EC 004 458

Report of Citizens' Committee, Region I; Ohio Comprehensive Statewide Planning for Vocational Rehabilitation. July 1, 1966 to June 30, 1968.

Governor's Council on Vocational Rehabilitation, Toledo, Ohio.
Spons Agency-Rehabilitation Services Administration (DHEW), Washington, D.C.
Pub Date 68
Note-165p.
EDRS Price MF-$0.75 HC-$8.35
Descriptors-Alcoholism, Criminals, Drug Addiction, Emotionally Disturbed, *Exceptional Child Services, Interagency Coordination, Manpower Needs, Mentally Handicapped, Physically Handicapped, *Program Evaluation, *Program Planning, Regional Planning, Rehabilitation Centers, Sheltered Workshops, Socially Maladjusted, *State Programs, *Vocational Rehabilitation
Identifiers-Ohio

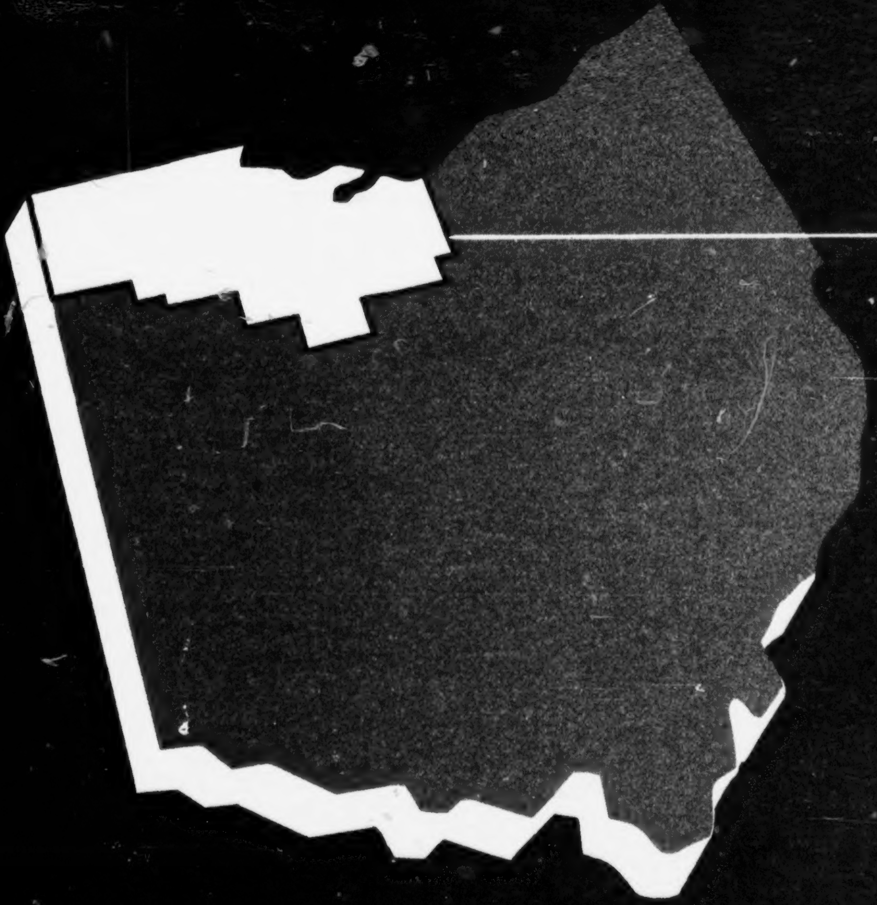
The work of six citizen task forces in comprehensive planning for vocational rehabilitation in one region in Ohio is described. Their combined findings are summarized and recommendations presented in the areas of facilities and programs, personnel, coordination, public information, and finance. The regional study plan is defined in terms of its general structure and of the study plans of the individual task forces on physical, mental, and social disabilities, manpower, interagency coordination, and facilities and workshops. Findings of each of the six task forces are reviewed along with general supportive data and the master plan for implementation, coordination, and continued planning. Additional information on the individual task forces is appended; 12 descriptive tables are also provided. (JD)

ED0 32676

REPORT OF

CITIZENS' COMMITTEE OHIO COMPREHENSIVE STATEWIDE PLANNING FOR VOCATIONAL REHABILITATION

JULY 1, 1966–JUNE 30, 1968



REGION I

- DEFIANCE
- ERIE
- FULTON
- HANCOCK
- HENRY
- HURON
- LUCAS
- OTTAWA
- SANDUSKY
- SENECA
- WILLIAMS
- WOOD
- WYANDOT

COUNTIES

GOVERNOR'S COUNCIL ON VOCATIONAL REHABILITATION

"DISCRIMINATION PROHIBITED--Title VI of the Civil Rights Act of 1964 states: 'No person in the United States shall, on the grounds of race, color, or national origin, be excluded from participation in, be denied the benefits of, or be subjected to discrimination under any program or activity receiving Federal financial assistance.' Therefore, all programs and activities receiving financial assistance from the Department of Health, Education, and Welfare must be operated in compliance with this law."

Library of Congress Catalog Card Number: 68-65058

REPORT

of

CITIZENS' COMMITTEE

REGION I

OHIO
COMPREHENSIVE STATEWIDE PLANNING
for
VOCATIONAL REHABILITATION

July 1, 1966 to June 30, 1968

Frank F. A. Rawling, M.D.
Chairman

Douglas Burleigh
Regional Coordinator

U.S. DEPARTMENT OF HEALTH, EDUCATION & WELFARE
OFFICE OF EDUCATION

THIS DOCUMENT HAS BEEN REPRODUCED EXACTLY AS RECEIVED FROM THE PERSON OR ORGANIZATION ORIGINATING IT. POINTS OF VIEW OR OPINIONS STATED DO NOT NECESSARILY REPRESENT OFFICIAL OFFICE OF EDUCATION POSITION OR POLICY.

Governor's Council on Vocational Rehabilitation
Ohio Comprehensive Statewide Planning

JAMES A. RHODES
Governor

CHAIRMAN
William H. Eells
EXECUTIVE SECRETARY
Robert L. Davis
MEMBERS OF COUNCIL
Mrs. Alfred B. Lavin
Canton
*Mrs. Ethel Swanbeck
Huron
Chester H. Allen, M.D.
Portsmouth
*W. G. Bleakley
Lima
William S. Carlson, Ph.D.
Toledo
Jonathan L. Collens
Cleveland
J. K. Cozier
Cleveland
*Willis D. Gradison, Jr.
Cincinnati
*Martin Graham
Brooklyn
Robert E. Kline
Dayton
William O. Littick
Zanesville
Charles J. Miller
Cleveland
Edward J. Moriarty
Columbus
ex officio
Dean Phillips
Columbus
Frank T. Rhoad, Jr.
Cincinnati
Frank F. A. Rawling, M.D.
Toledo
Harold D. Roth
Upper Sandusky
Thomas J. Starks
St. Clairsville
Everett Steece
Columbus
ex officio
W. Chandler Stevens, Jr.
Lexington
David Tilton
Columbus
ex officio
Paul L. Walker
Columbus
***EXECUTIVE COMMITTEE**
PLANNING STAFF
Robert L. Davis
Project Director
David H. Tait, Ed.D.
Associate Director and
Research Coordinator
George E. Reavell
State Coordinator
REGIONAL COORDINATORS
Douglas L. Burleigh
Toledo
Ruth U. Mitchell
Magdalena Miranda
(associate coordinator)
Cleveland
Robert Ash
Canton
Lowell D. Bassett
Columbus
Mary J. Mendez
Cincinnati
George E. Reavell
(acting coordinator)
Dayton

1614 South Byrne Road
Toledo 14, Ohio
March 5, 1968

Mr. William H. Eells
Chairman
Governor's Council on
Vocational Rehabilitation
240 Parsons Avenue
Columbus, Ohio

Dear Mr. Eells:

On behalf of the citizens of Northwestern Ohio serving on the Citizens' Committee, Region I, I submit our final report.

There are many significant findings in this report that should be of vital importance to all citizens in Ohio. They have a direct bearing on the challenge of rehabilitating citizens who through illness or accident have been removed from the mainstream of life. Our orientation is toward returning these citizens to a productive useful life. We are convinced that implementation of our recommendations is an opportunity for an investment that will yield returns far beyond our expectations.

Sincerely yours,

Frank FARawling

Frank F. A. Rawling, M.D.
Chairman
Regional Citizens' Committee
Region I

FFAR/nas

Enclosure

240 PARSONS AVENUE, RM. 125 • COLUMBUS, OHIO 43215 • (614) 469-2444

Acknowledgements

While this report is entitled "The Final Report of Region I Citizens' Committee", all of us who have been involved in this study the past year sincerely trust that rather than it being final, it will provide a springboard for continuing planning and implementation in this vital field of rehabilitation. The past year has been an enriching one for us all. We have seen 180 citizens become involved in this study; and without their active participation, nothing could have been accomplished.

We received utmost cooperation from all those agencies and bureaus engaged in rehabilitation. At no time was there evident any reserve in sharing opinions and resources. Mr. R. Thayer Church, Regional Supervisor of the Bureau of Vocational Rehabilitation, and his staff throughout the region were a great source of strength. Mrs. Mary Smith acted as the secretary to our Executive Committee and we thank her.

Our coordinator, Douglas Burleigh, has been our right arm. His diligence and industry are reflected in the report that we submit.

Our Task Force Chairmen have stayed on the job the entire year holding many meetings and traveling throughout our region gathering facts for our study. I feel a great sense of personal gratitude to them all including Dr. Robert Gosling and Father Weltin who led our Physical Disabilities Task Force, Mr. Samuel Long of our Manpower Committee, Judge Franklin and Mr. William Smith who did pioneer work in the field of Social Disabilities, Mr. Dan Seeman and his workers on the Mental Disabilities Task Force and Mr. Chris Regas and his members on the Inter-Agency Coordination Task Force. Dr. Glidden Brooks, President of the Medical College of Ohio at Toledo, has provided us all with excellent counsel and advice.

Particularly, do I wish to acknowledge the contributions of Dr. Jack Hutchison. He and his committee were responsible for an excellent report on Facilities and Workshops in Region I. On several occasions he participated in State meetings representing Region I. Finally, the arrangements for our successful Institute at Bowling Green were largely his. All of us are grateful for his contributions to this study.

All these people and many more have made this report possible. It has been a real privilege and inspiration to work with them in this study. We have all profited, and look forward to continuing our efforts on behalf of rehabilitation.

Frank F. A. Rawling, M.D.
Chairman
Regional Citizens' Committee

ORGANIZATION OF REGION I CITIZENS

I. Regional Citizens' Committee

Chairman - F. A. Rawling, M. D.

Co-Chairman - Dr. William Carlson, President
University of Toledo
Member of Governor's Council

*Robert Bennett - Area Manager
Ohio State Employment Service
724 Monroe Street, Toledo, Ohio

James Bond, Ph. D.
Vice-President
Bowling Green University
Bowling Green, Ohio

George Booth, M. D.
Secor Hotel
Toledo, Ohio

*Clarence Borgelt
Secretary-Treasurer
Toledo Area AFL-CIO Council
425 Winthrop Street
Toledo, Ohio 43620

**Dr. Glidden Brooks, President
Medical College of Ohio at Toledo
1614 South Byrne Road
Toledo, Ohio 43614

*Paul Brown, Executive Director (Retired)
Betty Jane Memorial Rehabilitation Center
65 St. Francis Avenue
Tiffin, Ohio 44883

*David Drury
Public Affairs, News/Editorial Director
WSPD T.V.
136 Huron Street
Toledo, Ohio

**Judge Robert Franklin
Toledo Municipal Court
Safety Building
525 Erie Street
Toledo, Ohio 43624

VI

**Robert J. Gosling, M. D.
3939 Monroe Street
Toledo, Ohio

*Albert Hage
Chamber of Commerce - Industrial Division
218 Huron Street
Toledo, Ohio

Judge Charles Ham
Wauseon, Ohio

*Walter Hartough
Goerlich's Incorporated
3539 Glendale Avenue
Toledo, Ohio 43601

*Harry H. Hollinger, M. D.
3124 Tremainsville Road
Toledo, Ohio 43613

**Jack Hutchison, Ph. D.
Coordinator, Rehabilitation Counelor Education
Bowling Green Univerity
Bowling Green, Ohio

*Martin Kutnyak
Executive Director
Toledo Hearing and Speech Center
2313 Ashland Avenue
Toledo, Ohio 43620

Mel Lanzer
Napoleon, Ohio

**Samuel S. Long
Executive Secretary
Hospital Planning Association of Greater Toledo
2243 Ashland Avenue
Toledo, Ohio 43620

*Harry P. Morell
Executive Secretary
Northwestern Ohio Building and Construction
Trades Council
912 Adams Street
Toledo, Ohio

William L. Ramsey, Ph. D.
Superintendent of Schools
Penta County Vocational School and Technical College
30335 Oregon Road
Perrysburg, Ohio

**Chris Regas
Executive Vice-President
United Appeals, Community Chest
American Red Cross of Greater Toledo Area
443 Huron Street
Toledo, Ohio 43604

**Daniel C. Seemann
Assistant Dean
University of Toledo Community and Technical College
2801 West Bancroft Street
Toledo, Ohio

*Arthur C. Schrader
Director, Adult Education
Toledo Board of Education
1501 Monroe Street
Toledo, Ohio 43624

Jay Shuer
839-895 Champlain Street
Toledo, Ohio 43604

*Reverend Garnet Phibbs
Council of Churches
Board of Trade Building
Toledo, Ohio

Judge Donald Wargowski
Probate and Juvenile Court
Port Clinton, Ohio 43452

*Task Force Member
**Task Force Chairman or Co-Chairman

II Ex-Officio on Regional Citizens' Committee and All Task Forces

R. Thayer Church, Supervisor
Ohio Bureau of Vocational Rehabilitation
Region I
510 Gardner Building
Toledo, Ohio, Ohio 43604

Joseph F. Sullivan, Supervisor
Ohio Bureau of Services for the Blind
Region I
724 Monroe Street
Toledo, Ohio 43604

Mary S. Smith, Supervisor
Toledo, State Hospital Unit
Ohio Bureau of Vocational Rehabilitation
Toledo State Hospital
Toledo, Ohio Box 2027

Douglas L. Burleigh, Coordinator
Statewide Planning for Vocational Rehabilitation
Region I
510 Gardner Building
Toledo, Ohio 43604

III. Task Force Members by Task Force

A. Physical Disabilities Task Force

Chairman: Robert J. Gosling, M. D.
3939 Monroe Street
Toledo, Ohio 43606

Members: Walter Hartough
Goerlich's Incorporated
3539 Glendale Avenue
Toledo, Ohio 43601

Harry H. Hollinger, M. D.
3124 Tremainsville Road
Toledo, Ohio 43613

Martin M. Kutnyak
Executive Director
Toledo Hearing and Speech Center
2313 Ashland Avenue
Toledo, Ohio 43620

Father Roman G. Weltin
St. Johns High School
5900 Airport Highway
Toledo, Ohio

Frank Baumgartner, R.P.T.
Mercy Hospital
2221 Madison Avenue
Toledo, Ohio

Mrs. Betty Grottke
Northwest Ohio Heart Association
230 Board of Trade Building
Toledo, Ohio

Miss Patricia Ryan, R.P.T.
Visiting Nurse Service
635 N. Erie Street
Toledo, Ohio

B. Mental Disabilities Task Force

Chairman: Daniel C. Seeman
Director of Student Activities
University of Toledo
2801 W. Bancroft Street
Toledo, Ohio

B. Mental Disabilities Task Force (continued)

Members:

Herbert Baker, Ed. D., Director
Luella Cummings Home
123 - 22nd Street
Toledo, Ohio

Robert Carson, Director
Pupil Personnel Service
Toledo Board of Education
Manhattan Boulevard
Toledo, Ohio

David Drury, Director
News/Editorial
WSPD T.V.
136 Huron Street
Toledo, Ohio

James Lauber, Ph. D.
Chief Psychologist
Toledo State Hospital
5 South Detroit Avenue
Toledo, Ohio

Walter Solarz, Coordinator
Retarded Children's Program
1155 Larc Lane
Toledo, Ohio

Phyllis Stephens
Psychiatric Social Worker
Mental Hygiene Clinic
2253 Ashland Avenue
Toledo, Ohio

Jack Vanderveer, M. D.
Psychiatrist
4303 Monroe Street
Toledo, Ohio

Ohma Willette
Statewide Planning for Mental Retardation
443 Huron Street
Toledo, Ohio

Dr. William Easson, Chairman
Department of Psychiatry
Medical College of Ohio at Toledo
2801 West Bancroft
Toledo, Ohio

Dr. Robert F. Hopkins, Director
Counseling Bureau
University of Toledo
Toledo, Ohio

C. Social Disabilities Task Force

Chairman:	Judge Robert V. Franklin Toledo Municipal Court Safety Building 525 Erie Street Toledo, Ohio 43624
Co-Chairman:	James A. Smith, Executive Director North Toledo Community House 3201 Stickney Avenue Toledo, Ohio 43608
Members:	Chris Christoff, Chief Probation Officer Lucas County Safety Building 525 Erie Street Toledo, Ohio 43624
	Edward Evans, Assistant Commissioner City of Toledo, Division of Recreation 2011 Ottawa Drive Toledo, Ohio 43604
	Judge Charles Ham Wauseon, Ohio
	Mrs. Charlotte Shaffer, Executive Secretary Toledo Council of Social Agencies 441 Huron Street Toledo, Ohio 43604
	Judge Frank Wiley Municipal Court 525 Erie Street Toledo, Ohio 43604
	Lawrence A. Calfee, Jr., Instructor Waite Senior High School Morrison Drive and Second Toledo, Ohio

D. Manpower Task Force

Chairman:	Samuel L. Long, Executive Secretary Hospital Planning Association of Greater Toledo 2243 Ashland Avenue Toledo, Ohio 43620
Members:	Richard F. Baer, M. D. 3939 Monroe Street Toledo, Ohio 43606
	Robert Bennett, Area Manager Ohio State Employment Service 724 Monroe Street Toledo, Ohio 43604

D. Manpower Task Force (continued)

Clarnece Borgelt
Secretary-Treasurer
Toledo Area AFL-CIO Council
425 Winthrop Street
Toledo, Ohio 43620

Mr. Edward Brewer
Executive Director
Goodwill Industries of Toledo, Inc.
931 N. Hawley Street
Toledo, Ohio

Albert Hage
Chamber of Commerce - Industrial Division
218 Huron Street
Toledo, Ohio 43604

Harry P. Morell, Executive Secretary
Northwestern Ohio Building and
Construction Trade Council
912 Adams Street
Toledo, Ohio 43624

E. Facilities and Workshops Task Force

Chairman: Jack Hutchison, Ph. D.
Coordinator
Rehabilitation Counselor Education
Bowling Green University
Bowling Green, Ohio

Members: Grant Brown
County Commissioner
Court House
Bryan, Ohio

Paul Brown, Former Director
Betty Jane Memorial Rehabilitation Center
65 St. Francis Avenue
Tiffin, Ohio

J. Creighton Ghrist, Director
Ehode Joint Vocational School
1200 Sycamore Line
Sandusky, Ohio

William P. Gregg, Coordinator
Rehabilitation Facilities and Workshop Planning
Bureau of Vocational Rehabilitation
240 South Parsons Avenue, Room 125
Columbus, Ohio 43215

E. Facilities and Workshops Task Force (continued)

Dorwin J. Laessle, Supervisor
Trade and Industrial Education
Sandusky Public Schools
Sandusky, Ohio

Paul R. Lankenau
Attorney-at-Law
Napoleon, Ohio

Roy A. Miller, Supervisor
Trade and Industrial Education
Fremont City Schools
1100 North Street
Fremont, Ohio 43420

Jake Pool, Executive Director
Betty Jane Memorial Rehabilitation Center
65 St. Francis Avenue
Tiffin, Ohio

Dr. William Ramsey
Penta County Technical College
Superintendent of Schools
30335 Oregon Road
Perrysburg, Ohio

Arthur Schraeder, Director
Adult Education
Toledo Board of Education
Administration Building
Manhattan & Elm Streets
Toledo, Ohio

F. Inter-Agency Coordination Task Force

Chairman: Glidden L. Brooks, M. D., President
Toledo School of Medicine
1614 South Byrne Road
Toledo, Ohio 43614

Co-Chairman: Chris Regas, Executive Vice-President
United Appeal
443 Huron Street
Toledo, Ohio 43604

Members: Reverend J. E. Braun
636 Harrison Street
Port Clinton, Ohio

F. Inter-Agency Coordination Task Force (continued)

Mrs. Henry M. Dodge
R. R. # 4
Bowling Green, Ohio

Paul Engelmann, Associate Director
United Appeal
443 Huron Street
Toledo, Ohio 43604

Dr. William J. Jerome, President
Bowling Green University
Bowling Green, Ohio

Mr. Robert Knight, Vice-President
Ohio Citizens' Trust
405 Madison Avenue
Toledo, Ohio 43604

Mr. Carleton Rae, Chapter Manager
American Red Cross
2205 Collingwood Boulevard
Toledo, Ohio 43620

Mrs. Charlotte L. Shaffer, Executive Secretary
Toledo Council of Social Agencies
441 Huron Street
Toledo, Ohio 43604

TABLE OF CONTENTS

Page

Title Page
Letter of Transmittal i
Acknowledgements iii
Organization of Regional Citizens v

Table of Contents xv
List of Tables xvii

Chapter I: Introduction

A. Philosophy 1
B. Definition of Basic Terms 2
C. Setting 3
D. Need 7
E. Purpose 12
F. Method 13

Chapter II: Summary

A. Problem 15
B. Findings 15
C. Conclusions 18

Chapter III: Recommendations

A. Facilities 21
B. Personnel 22
C. Coordination 22
D. Public Information 23
E. Finance 24

Chapter IV: Regional Study Plan

A. General Structure 25
B. Individual Task Force Study Plans 29
    1. Task Force on Physical Disabilities 30
    2. Task Force on Mental Disabilities 31
    3. Task Force on Social Disabilities 32
    4. Task Force on Manpower 33
    5. Task Force on Inter-Agency Coordination 34
    6. Task Force on Facilities and Workshops 34

Chapter V: Task Force Findings

A. Task Force on Physical Disabilities 37
B. Task Force on Mental Disabilities 44
C. Task Force on Social Disabilities 51
D. Task Force on Manpower 57
E. Task Force on Inter-Agency Coordination 61
F. Task Force on Facilities and Workshops 63

Page

Chapter VI: General Supportive Data
- A. Literature - Related Studies 73
- B. Seminar Abstracts: Region I Institute on Rehabilitation; Bowling Green, Ohio; December 14, 1967 75
- C. Incidence and Prevalence Information 76

Chapter VII: Region I Master Plan
- A. Regional Rehabilitation Council for Implementation, Coordination and Continued Planning 81
- B. Phase of Implementation 82

VIII: APPENDICES

A. Task Force on Physical Disabilities 83

B. Task Force on Mental Disabilities 105

C. Task Force on Social Disabilities 111

D. Task Force on Manpower 117

E. Task Force on Inter-Agency Coordination 127

F. Task Force on Facilities and Workshops 133

LIST OF TABLES

Page

Table 1: Region I Population Estimates 5

Table 2: Certain Characteristics of the Population in Region I, by County 6

Table 3: Ohio Labor Force Estimates by County 8

Table 4: Economic Ranking of Counties per Region 9

Table 5: Major Industry in Region I 10

Table 6: Organizational Chart 26

Table 7: Task Force Representation by Discipline 27

Table 8: Chronology of Major Meeting Dates 28

Table 9: Incidence of Mental Disabilities 46

Table 10: Inmates in all Ohio Adult Correction Institutions; and Court Commitments to all Ohio Adult Correction Institutions 56

Table 11: Incidence of Physical Disabilities 77

Table 12: Region I - Estimated Projections of Population (in thousands) 79

CHAPTER I

INTRODUCTION

Chapter I: Introduction

A. Philosophy

The concept of "rehabilitation" applied in any area of endeavor, may be understood in terms of something being raised from a status of inadequacy to a status of adequacy.[1] A decaying and abandoned section of a business district may be leveled and made ready for a shopping center or a parking lot or a much used car may be given a fresh painting and a new set of tires. Generally, though, with our society's current heightened social awareness and sensitivity to human needs, the word "rehabilitation" popularly denotes assisting people.

The National Council on Rehabilitation (Circa 1943) issued a definition of rehabilitation which is still widely quoted and used: "rehabilitation is the restoration of the handicapped to the fullest physical, mental, social, vocational and economic usefullness of which they are capable."[2] Rehabilitation is also "the cultivation, restoration, and conservation of human resources."[3]

If one follows the line of reasoning inherent in these definitions, it would appear that an individual's need for "rehabilitation" indicates that he is in a state of disadvantage: he may be in less than satisfactory health; he may, concurrently, not be earning a salary nor engaged in a vocation commensurate with his potential. He may be existing on a sub-healthful level of income, for any of a number of reasons: inadequate education, too old, prison record, physical disability, a past history of mental illness, etc. He may be disadvantaged, or disabled, or impaired to a degree that he (1) cannot care for his own personal needs, and/or (2) is unable to become financially independent. In general, he is not a self-sustaining, nor "productive", nor contributing member of the community. He is handicapped!

It is the philosophy of the many citizens involved in this two year study (1) that the basic value and worth of man requires any correctable state of disadvantage to be remedied, (2) that there are services which will enable such states of disadvantage to be remedied, and (3) that it is the communities' responsibility to examine the number of people in such states, what services currently exist to help them, and what steps should immediately be taken to provide whatever quantity and quality of services are needed to assist all in need.

---

[1] Oberman, C. Esco, A History of Vocational Rehabilitation in America, Chapter II, p. 41.

[2] Allan, W. Scott, Rehabilitation: A Community Challenge, Chapter I, p. 2.

[3] Whitehouse, F. A., "Rehabilitation as a Concept in the Utilization of Human Resources", (In the Evolving Concept of Rehabilitation, Social Work Pratice in Medical Care and Rehabilitation Settings, Monograph I) pp. 17-37.

B. Definition of Basic Terms

Disability: A disability is a condition of impairment, physical, mental, or social, whether congenital or acquired by accident, injury, disease, or enviromental circumstances which totally or partially incapacitates an individual.

Handicapped Person: A handicapped person is one who because of the existence of a disability is hampered in attaining the fullest physical, mental, social, vocational and economic usefullness of which he is capable.

Rehabilitation: The definition of the term "rehabilitation" issued by the National Council on Rehabilitation in 1942 is still widely accepted:

> "Rehabilitation is the process of restoring the handicapped individual to the fullest physical, mental, social, vocational and economic usefulness of which he is capable."

This definition contemplates a process of helping each individual to reach the highest capacity for usefulness of which he is capable. Just as there is a tremendous variation in the degree of complexity of the individual case requiring rehabilitation, so too will there be great variations in the rehabilitation services required.

. . . Many cases can be rehabilitated through the services of their physicians with assistance from a hospital.

. . . Some simple cases might require only a few services such as physical therapy or speech therapy.

. . . Severe cases of multiple disability can benefit from the wide range of comprehensive services provided in a rehabilitation center.

The goals of rehabilitation will likewise vary from individual to individual, depending on his particular needs. In one case, the disability might be eliminated and the individual completely restored to his previous state of usefulness. In another case where the disability will prevent return to his former job, physical restoration services may be necessary including help to achieve a maximum adjustment to the remaining disability and training to enter a new occupation. For the large categories of cases where regular employment is not a feasible goal, rehabilitation services may be directed to other goals such as:

1. Independent living for those severely handicapped people who can be helped to achieve a measure of independence in the activities of daily living and self-care.

2. Limited employment opportunities in sheltered or homebound employment.

C. Setting

1. Historical Sketch

Comprehensive Statewide Planning for Vocational Rehabilitation Services is a nation-wide project. The impetus for this study originated within the Federal Rehabilitation Services Administration, (formerly the Vocational Rehabilitation Administration) Department of Health, Education and Welfare. In 1965, P.L. 89-333 made funds available to each state to conduct a comprehensive study of the number and needs of its handicapped citizens. To understand why such a study was encouraged, a general background of the State-Federal Vocational Rehabilitation program must be considered.

In 1920, the Federal Government established an agency to provide guidance and counseling, tuition and supplies, prosthesis and placement services to the physically disabled. This federal agency administered funds on a matching basis to any State which desired to adopt such a program. The Federal agency assisted the member states in developing their programs; but, offered little beyond this guidance. For the next twenty years, the Federal agency was switched from one department to another, types of service offered were expanded and, periodically, Federal appropriation to the member states were increased. By 1943, every state and territory had initiated a vocational rehabilitation program (Ohio Bureau of Vocational Rehabilitation in 1921); many more services had been added and were extended to the emotionally disturbed and mentally retarded, as well as the physically disabled. In 1954, the Federal agency expanded its responsibilities and offered grants for research, staff development and for establishing facilities and workshops. By 1965, the individual State Vocational Rehabilitation agencies were receiving more money from the Federal Government, were increasing their staffs and were serving more handicapped citizens (200,000 a year were being placed in jobs). The Federal agency was spending more time surveying the rehabilitation needs of the country, encouraging and supporting research in the prevention, diagnosis and treatment of disabilities; improving the quality of vocational evaluation, training and placement; and considering other areas in which the concept of rehabilitation should be applied.

In 1965, P. L. 89-333 allowed the State-Federal system of Vocational Rehabilitation agencies to extend their services to the Socially Disabled (Public Offender, Alcoholic and Drug Addict). By this time the R.S.A. was aware that this additional responsibility, combined with the yearly increase in the number of physically and mentally disabled, required a close and detailed look at the size of job facing all agencies (public, private and voluntary) working with the disabled. So in 1965, the R.S.A. requested that funds be made available to every State to conduct a comprehensive study of this problem.

2. Authority

In November of 1966, Governor James A. Rhodes appointed a Governor's Council on Vocational Rehabilitation and directed this Council to "plan and conduct a statewide comprehensive study of Ohio's vocational rehabilitation resources and needs... determining the number and categories of disabled Ohioans... immediate and long range goals for vocational rehabilitation... public and private resources ... required to meet present and future needs" and "ways in which ... (existing) ... services for the handicapped may be recruited and utilized to facilitate and implement a statewide vocational rehabilitation program". Co-sponsors of this study were the Ohio Bureau of Vocational Rehabilitation and the Ohio Bureau of Services for the Blind. The Governor's Council selected an Executive Secretary who, under the co-sponsorship mentioned above, subsequently designed an approach to the problem in keeping with the philosophy of the Council.

3. Scope

a. Location

Study Region I encompasses thirteen counties in Northwestern Ohio: Defiance, Erie, Fulton, Hancock, Henry, Huron, Lucas, Ottawa, Sandusky, Seneca, Williams, Wood, and Wyandot.

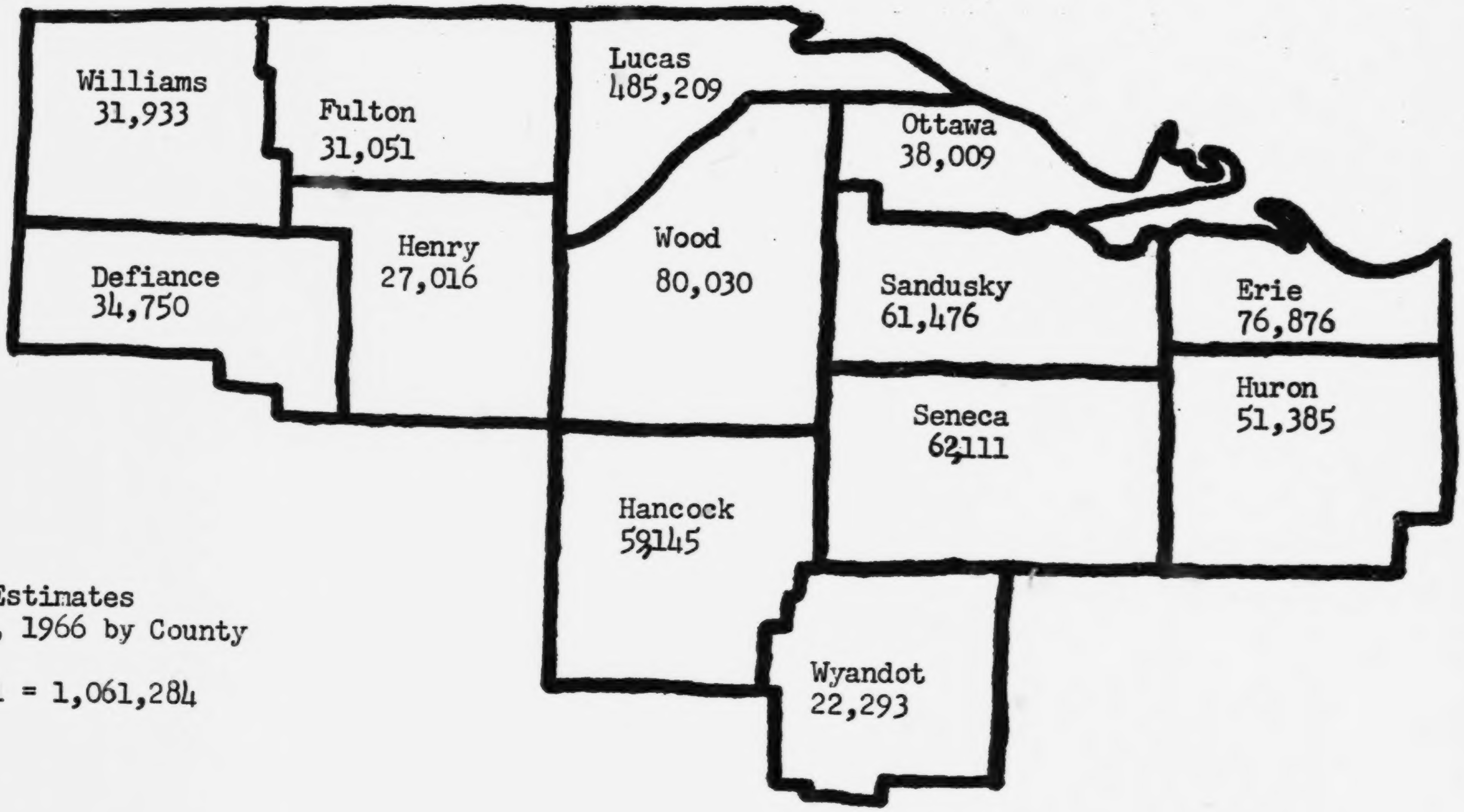
b. Population

Region I has a total population of 1,061,284 (effective January 1, 1966). Table 1 presents a county breakdown of this figure. Lucas County, with Toledo as the largest city in the Region, is the most heavily populated of the counties.

Table 2, Column 1, displays the percentage of county residents living in rural areas: rural non-farm and rural farm. Lucas County is the most highly urbanized with the majority of the population residing in Toledo. Williams, Fulton, Henry and Wyandot Counties have the proportionately greatest rural population with their accent on agricultural production.

Table 2, Column 5, displays the median school years completed by those individuals twenty-five years of age and older in each of the thirteen counties. The median number of years for the entire state is 10.9, with the highest median level of completion at 12.1 for Geauga and Greene Counties and the lowest at 8.6 years in Adams County. There are only five counties in Region I at or below the State median and, half the population of all counties has at least a tenth grade education.

Table 1


Williams
31,933
Fulton
31,051
Lucas
485,209
Ottawa
38,009
Defiance
34,750
Henry
27,016
Wood
80,030
Sandusky
61,476
Erie
76,876
Huron
51,385
Seneca
62,111
Hancock
59,145
Wyandot
22,293

Region I
Population Estimates
Jan 1, 1966 by County

Region total = 1,061,284

Table 2

CERTAIN CHARACTERISTICS OF THE POPULATION IN REGION I, BY COUNTY

(From 1960 U. S. Census of Population, Final Report, Pc Cl) - 37C, 1962 - Ohio

COUNTY	POPULATION % Rural non-farm	POPULATION % Rural farm	Median Income of Families	% of Population With Family Income Under $3000/yr	% of Population Unemployed	Median School Years Completed Age 25 & Older	% of Workers Commuting to job Outside of County
Defiance	22.9	21.0	5,643	18.2	5.3	11.1	16
Erie	28.4	5.3	6,189	13.5	9.7	11.0	11
Fulton	55.7 *.	29.6	5,451	20.3	4.2	11.3	20
Hancock	22.3	15.7	5,721	18.6	4.2	12.0	14
Henry	42.4	31.0 *	5,343	20.7	4.1	10.8	16
Huron	35.7	16.4	5,839	18.2	5.4	11.1	16
Lucas	6.5 **	0.8 **	6,533	13.9	6.5	10.7	--
Ottawa	59.7	12.6	5,908	15.1	5.7	10.5	20
Sandusky	34.9	13.2	5,707	16.8	5.5	11.1	16
Seneca	28.3	14.6	5,601	17.5	4.4	10.9	12
Williams	38.1	23.5	5,341	20.6	3.7	11.4	.08
Wood	42.9	13.1	6,157	15.3	4.5	11.6	30
Wyandot	34.5	25.4	5,203	22.9	4.4	10.8	20
Entire State	21.3	5.4	6,171	15.7	5.5	10.9	--
Range: Highest in State -	*		Lake 7,146	52.4 Adams	11.1 Meigs	Geauga 12.1 Greene	--
Lowest in State -	**		Adams 2,829	7.2 Lake	2.8 Holmes	8.6 Adams	--

In 1960, the U.S. Census revealed that across the State of Ohio, 5.5 per cent of the population was unemployed, with a low of 2.8 per cent unemployed in Holmes County and a high of 11.1 per cent unemployed in Meigs County. In Region I, Erie County had the highest unemployment rate at 9.7 per cent and Williams had the lowest at 3.7 per cent. Table 3 displays 1967 unemployment statistics compiled by the Ohio Bureau of Unemployment Compensation. Although this report is based on numbers of persons filing claims for unemployment compensation, rather than on a comprehensive census, it does offer a measure of unemployment which shows its decreasing rate in the 13 counties during the past seven years. Column 6 in Table 2 displays the percentage of workers (as of 1960) commuting to jobs outside their respective counties. There is an apparent relationship between extra-county commuting, rural residence and proximity to Toledo. It is generally understood that Toledo industry supplies jobs to a significant proportion of the Region I population.

Table 2 , Column 2, displays the median family income in each of the 13 counties. Eleven of the counties have a median family income below the State median. Table 4 displays an economic ranking of the 13 counties. This ranking is based on the Total Effective Buying Income (total personal income - taxes). With rank number 44 as the median or middle rank, it is noted that six of the Region I counties fall below it. Table 2 , Column 3 displays the percentage of the population with family incomes below $3000 a year. Nine of the 13 counties have a percentage greater than the State median percentage of 15.7 per cent. Taken collectively, all three tables indicate that the purchasing power and affluence of the majority of the families in Region I are below the State average.

c. Industry

There is an abundance and diversity of jobs available in Region I. Table 5 displays, by county, the major industries in the Region. Industry is only one area of employment; yet, it is a significant indicator of the all possibilities for employment in any location. It can be inferred from these listings that individuals with varying levels of educational achievement, training and talent may find employment in Region I.

d. Need

It is understood that several relevant phenomena, acting concurrently and inter-relatedly, have yielded the need for this comprehensive evaluation of rehabilitation needs. Four of the more visible phenomena will be examined herein.

Table 3

OHIO LABOR FORCE ESTIMATES, BY COUNTY*

The Bureau of Unemployment Compensation, aided by its local network of Ohio State Employment Service Offices, prepares periodic Labor Force Reports for each of Ohio's 88 counties. These one-page statements, updated every four months, offer current estimates of the labor force, employment, and unemployment, as well as qualitative information on the labor supply.

This report is based on figures available as of February 28, 1967.

County	Employment	Unemployment	Rate
Defiance	15,900	450	2.8
Erie	28,600	1,000	3.4
Fulton	12,800	400	3.0
Hancock	22,400	600	2.6
Henry	10,050	250	2.4
Huron	18,700	500	2.6
Lucas	203,500	6,100	2.9
Ottawa	10,400	400	3.7
Sandusky	21,750	550	2.5
Seneca	23,700	700	2.9
Williams	13,600	400	2.9
Wood	29,500	800	2.6
Wyandot	6,800	175	2.5
Total	417,700	12,325	—

---

* Sum of employment (which includes workers involved in labor-management disputes) and unemployment equals estimated civilian labor force. Rate is unemployment divided by civilian labor force. Employment estimates are geared to county of work, rather than county of work, rather than county of residence; unemployment estimates are affected by the number of claimants filing in a county, regardless of county of residence or former place of work.

Division of Research and Statistics
Ohio Bureau of Unemployment Compensation
Columbus 2/28/67

TABLE 4

ECONOMIC RANKING OF COUNTIES PER REGION*

Region I

Rank in Region	County	TEBI In Thousands Of Dollars	Rank in State
1	Lucas	1,257,864	6
2	Wood	177,562	24
3	Erie	176,865	25
4	Hancock	135,493	36
5	Sandusky	130,335	37
6	Seneca	128.875	38
7	Huron	102,705	42
			-- 44 Median
8	Ottawa	79,945	49
9	Defiance	69,249	53
10	Williams	62,136	60
11	Fulton	61,345	62
12	Henry	50,602	66
13	Wyandot	41,487	74

* -- based on TEBI (Total Effective Buying Income) = Total Personal Income Minus Taxes.

"Sales Management, Inc. is pleased to extend to Governor's Council on Vocational Rehabilitation the right to reproduce copyrighted data from its 1966 Survey of Buying Power, with the proviso that all actual figures must be accompanied by the following notice, in full:

© 1966, Sales Management Survey of Buying Power; further reproduction is forbidden."

Table 5

MAJOR INDUSTRY IN REGION I

Defiance	Primary& Fabricated Metals	Stone Clay Glass	Food	Electrical Machinery	Non-Electrical Machinery	Transportation Equipment				
Erie	Electrical Machinery	Non-Elec Machinery	Publishing Printing	Furniture Fixtures	Stone-Clay Glass					
Fulton	1/8 Agriculture	Fabricated Metals	Electrical Machinery	Furniture Fixtures	Food	Transportation Equipment	Primary Metals	Paper		
Hancock	1/12 Agriculture	Electrical Machinery	Rubber	Food	Non-elec Machinery	Primary Metals	Printing Publishing		Stone-Clay Glass	
Henry	1/7 Agriculture	Food (majority)	Non-elec Machinery	Fabricated Metals	Rubber	Transportation Equipment				
Huron	1/12 Agriculture	Printing Publishing	Non-elec Machinery	Fabricated Metals	Food	Electrical Machinery	Transportation Equipment		Stone-Clay Glass	Apparel
Lucas	Motor Vehicles	Stone-Clay Glass	Electrical Machinery	Non-elec Machinery	Fabricated Metals	Primary Metals	Food			
Ottawa	Stone-Clay Glass	Rubber	Primary Metals	Food	Fabricated Metals	Machinery Non-elec				
Sandusky	1/12 Agriculture	Electrical Machinery	Non-Elec Machinery	Stone-Clay Glass	Food	Fabricated Metals	Apparel			
Seneca	Electrical Machinery	Non-elec Machinery	Stone-Clay Glass	Primary Metals	Fabricated Metals	Printing Publishing	Food	Rubber		
Williams	1/10 Agriculture	Non-elec Machinery	Electrical Machinery	Fabricated Metals	Toys	Transportation Equipment	Food	Rubber	Furniture	Chemicals
Wood	1/4 Government	Stone-Clay Glass	Fabricated Metal	Electrical Machinery	Non-elec Machinery	Transportation Equipment	Rubber			
Wyandot	1/2 Agriculture	Rubber	Plastics	Machinery	Electrical Machinery	Transportation Equipment	Food	Stone-Clay Glass		

Increase in Size of Disabled Population: It is a natural fact that the number of people in the United States is increasing yearly. Rather than remaining constant, the proportion of this increasing population that is physically and mentally disabled is also increasing. Advances in medical technology play no small part in each phenomenon. Research in Prenatal-Care and Obstetrics has held constant the birth rate. At the other end of the life span, we see men and women living longer. Advances in surgical techniques, medical treatment, and physical medicine have not only contributed to longer lives, but have yielded a number of people with residual disabilities. Thus, the numbers of agencies and programs which adequately served the disabled population ten years ago are underadequate today and will be totally and critically inadequate by 1975.

Expanded Application of Rehabilitation Concept: The philosophy and practice of rehabilitation techniques has been historically applied to the physically and mentally disabled. It is apparent that a certain percentage of the labor-force population is unemployed, for reasons other than physical or mental disabilities. With our expanding economy and yearly increasing Gross National Product, jobs are available for the qualified. It is observed that many who are unemployed are living off the tax dollar (Welfare in its various programs, A.D.C., A.D., O.A.A., etc.; Unemployment Compensation). Rehabilitation programs have been dedicated to assisting individuals towards more functionally independent lives and, if possible, economically and financially independent lives; subsequently, rehabilitation programs (e.g., Rehabilitation Services Administration) and other service programs (e.g., Office of Economic Opportunity, Federal, State and local Welfare offices) are initiating programs to train the unemployed for appropriate employment. In 1965, the Rehabilitation Services Administration stated that any interested and adequately equipped State Rehabilitation program could receive Federal funds to begin working with the unemployed who were in such circumstances because of addiction to alcohol, drugs or because they had a prison record or were, in general, culturally deprived. Thus, the target for rehabilitation services was enlarged.

Increase in Rehabilitative Programs and Agencies: Public agencies on the Federal level, State level, and the local level are increasingly developing rehabilitative treatment programs and directing research in various medical, educational and vocational areas of rehabilitation. Independent facilities, general hospitals, and voluntary health agencies increasingly are encouraging and supporting research in rehabilitation, developing facilities and workshops, purchasing services from facilities and workshops and lobbying for the development of rehabilitative programs. In Northwestern Ohio, during the past fifteen years, general hospitals have initiated Physical and Occupational Therapy programs;

voluntary health organizations are conducting clinics; local school systems have developed vocational-technical programs; County Welfare Departments have built workshops for the mentally retarded and physically disabled, and the list goes on. How can all of these facilities, workshops and programs be utilized to effect maximum services to all in need?

Prevalence of National, State and Areawide Rehabilitation and Health Studies: Within the past five years a number of studies initiated and funded on Federal, State and areawide levels have taken "comprehensive" views of services for the needs of various sub-groups of the population (e.g., the mentally ill, the mentally retarded, the stroke, cancer or heart disease victim, those in need of dental care, the chronically ill, etc.). Some of the studies more relevant to Statewide Planning for Vocational Rehabilitation are discussed in Chapter 5, Section A. The prevalence, of these kinds of studies, in itself does not support the need for another "comprehensive" study; yet accepting the "vogue-ness" of comprehensive-type studies, and accepting the current trend to super-impose the rehabilitation concept on various health and social service programs, the need is evident for taking a "rehabilitation view" of health, educational, vocational, social service, rehabilitation and rehabilitative agencies and programs in any community.

E. Purpose

1. To develop an understanding of the many rehabilitation needs of the physically, mentally and socially disabled people in Northwestern Ohio.

2. To determine how many are in need.

3. To determine what resources (either totally rehabilitative in nature, or offering some service or services considered as contributing to the rehabilitation process) currently offer services to the physically, mentally and socially disabled.

4. To determine what factors frustrate maximally effective delivery of services to these disabled people: e.g., shortage of facilities and workshops, inadequate staff, lack of educational programs to train professional staff, insufficient interagency communication, reticence of employers to hire disabled workers, etc.

5. To develop functional and realistic solutions to these problems, so that "all in need" may be served by 1975 or earlier.

F. Method

The Governor's Council on Vocational Rehabilitation assumed responsibility for conducting the Comprehensive Statewide Planning Study. On the Governor's Council were citizens from various professions and responsibilities and who represented seven study regions across the State. In each of the seven study regions was established a Regional Citizens' Committee which gave impetus and direction to the study in its region. The Chairman of the Regional Citizens' Committee was also a member of the Governor's Council.

From the Regional Citizens' Committee in Region I were chosen six men to chair six Task Forces concerned with gathering and evaluating information regarding the numbers and needs of the Physically, Mentally and Socially Disabled. The Task Forces were as follows: Physical Disabilities, Mental Disabilities, Social Disabilities, Manpower, Interagency Coordination and Facilities and Workshops.

The Task Forces gathered their information primarily from questionnaires, agency contacts, review of pertinent literature and study reports, and public and professional hearings throughout the thirteen counties. Eventually, during the past year, over 180 citizens were involved in the study.

A more detailed discussion of the study structure is found in Chapter IV.

CHAPTER
II
SUMMARY

Chapter II: Summary

A. Problem

At this time, there do not exist in Northwestern Ohio enough facilities and staff to serve all who require rehabilitation services. This deficiency will be dramatically enlarged by 1975, given the current rate at which the number in need are increasing and the slow pace at which programs and facilities for the disabled are being funded and developed.

B. Findings

The findings of the six citizen Task Forces, discussed in detail per individual Task Force in Chapter Five, are examined in the following section under five categories: Facilities and Programs, Personnel, Coordination, Public Information, and Finance.

1. Facilities and Programs

a. 66 Facilities and Workshops in Northwestern Ohio were indentified as providing rehabilitation services.

b. 60% of these defined Facilities and Workshops served 63,974 persons in 1966.

c. 60% of the indentified Facilities and Workshops served about 600 more people than the capacity of the buildings provide for; and, 1,783 people were on waiting lists for one year.

d. Facilities and Workshops in Lucas County serve people in most disability categories; six counties have no Facilities and Workshops whatsoever.

e. There is no one Facility or part of a Facility in Northwestern Ohio, which offers a comprehensive and multi-disciplinary approach to diagnosing all disabled individuals' needs.

f. Certain individuals because of their specific arrangement of characteristics such as disability, age, sex, economics status, etc. are unable to receive their prescribed services because no specific programs nor facilities exist to serve them.

g. With regard to the Socially Disabled, there are no facilities or programs which address themselves to the vocational and personal adjustment needs of these persons following their institutional treatment.

h. Facilities for the Mentally Disabled are overcrowded and no specific facility exists to deal with inpatient and outpatient care of the emotionally disturbed adolescent.

2. Personnel

   a. In rehabilitation facilities, workshops, and agencies throughout Northwestern Ohio, there are, at least 139 vacancies for professionals in the area of rehabilitation.

   b. These same facilities and agencies stated that by 1970, there will be a need for 665 professionals in all fields.

   c. The major source of personnel is universities.

   d. Two-thirds of the agencies surveyed indicated that there exists a lack of educational programs to supply the needed personnel.

   e. 50% of the rehabilitation agencies do not provide Staff Development programs.

   f. A significant proportion of all rehabilitation agencies express plans for expanding; yet, they question where they will obtain the subsequently required staff.

3. Coordination

   a. Of all the rehabilitation agencies contacted regarding the extent to which they communicated with and sent referrals to other rehabilitation agencies, only 45% provided the requested information.

   b. Of the agencies inventoried, few stated that they referred their clients to other agencies for other services.

   c. 77% of the selected rehabilitation agencies in Northwestern Ohio have specific methods of having clients referred to them.

   d. There does not exist in most of the communities in Northwestern Ohio an agency or office or group of professionals who can direct the provision of rehabilitation services to those in need; there is a lack of common bases on which agencies can interrelate and cooperate in providing a continuous arrangement of services specifically prescribed to meet each disabled individual's needs.

   e. It is evident that the majority of rehabilitation facilities and programs in Northwestern Ohio have plans for expanding during coming years; yet, planning is on an intra-agency or intra-community basis and displays a response to agency and local needs rather than to area-wide or regional needs.

4. Public Information

   a. "Rehabilitation" as defined and discussed in Chapter I is not understood and therefore, seldom practiced by the various sub-groups of the general population: M.D.'s, employers, legislators, lay citizens, etc.

b. The M.D. is accustomed to viewing and treating the immediate and local pathology and after satisfactorily remedying the acute difficulty, leaves the patient to arrange for the treatment of his other, concomitant, difficulties.

c. Most M.D.'s still adopt a narrow view of rehabilitation and consider it as providing physical therapy.

d. There is an expressed reticence on the part of employers to hire disabled workers. It is the concensus of employers that disabled workers have higher accident rates, are more tardy and delinquent, and evidence low quality and quantity of production.

e. The public is oblivious to the fact that 10 to 12 per cent of the population has a disablity to various limiting degrees and that although there are services designed to reduce limitation, there is a paucity of these services.

f. Generally, the public is unaware of the existence of public, private and voluntary rehabilitation programs; subsequently, the disabled don't know where to go for services, employers do not actively seek well trained workers from responsible vocational rehabilitation programs, M.D.'s seldom refer their patients to rehabilitation programs, and rehabilitation agencies are unaware of where to send their clients for services that the agencies themselves cannot provide.

5. Finance

a. The Ohio Bureau of Vocational Rehabilitation is one agency that administers State and Federal money in purchasing rehabilitation services from a majority of public, private and voluntary rehabilitation programs in order to serve disabled citizens of Ohio. It also uses this money to assist public and private agencies in improving their programs or in starting new programs.

b. Every other year the Federal government allots a specified amount of money to Ohio to be incorporated into the Ohio Bureau of Vocational Rehabilitation's budget. To receive the full federal allotment, Ohio's Legislature must appropriate an amount of money equal to 1/4 of the full federal allotment. Every year, the Ohio Legislature falls short of the needed appropriation and Ohio brings in only a small percentage of the federal allotment.

Year	Federal Allotment	%Ohio Brought In
1957	$ 934,134	46.5%
1961	1,561,705	64.9%
1966	11,462,543	24.6%

Subsequently, every year, the Ohio Bureau of Vocational Rehabilitation never has enough money to serve even a small percentage of the disabled who require rehabilitation services.

c. A significant number of rehabilitation agencies and programs will never be developed in Northwestern Ohio because of the lack of Bureau of Vocational Rehabilitation funds which the agencies recognize could be used to purchase their services and to partially support them.

C. Conclusions

As in the above section, general conclusions will be considered under five categories: Facilities and Programs, Personnel, Coordination, Public Information and Finance.

1. Facilities and Programs

a. Most of the facilities, workshops, agencies and/or programs inventoried are presently forced to extend services to more individuals than they are equipped to serve.

b. There are many excellent programs offering services to the disabled in Northwestern Ohio; yet, (1) they are scattered throughout the thirteen counties, (2) serving only one specific disability group here and offering only one or two services there. (3) Subsequently, they prevent an individual with one specific disabling condition from receiving, in one limited geographic area, all the various services required for his multi-phasic problem.

c. It is apparent that even though the services are scattered throughout the Region, clusters of services exist in the major population centers, and certain outlying localities have no "hometown" rehabilitation services and their citizens must travel from one community to another to obtain all the services they need.

d. No one facility, and generally no one community, offers all the services needed to evaluate the physical, mental, social and vocational problems raised by a disability; subsequently, no one facility nor community offers all services designed to treat these identified problems.

2. Personnel

a. There exists a generally inadequate number of personnel prepared to work with and for the disabled in Northwestern Ohio.

b. The existing facilities, workshops and agencies are currently understaffed and this problem will be increased by the agencies' expansion plans and by the continuous increase in the number requiring services.

c. Viewing the limited yearly output of rehabilitation professionals from the existing geographically remote schools of higher education, there is apparently little hope that the present and future number of needed professionals will be provided.

   d. Many communities in Northwestern Ohio lack the appeal sufficient to attract the numbers and quality of professionals required to perform the job at hand.

3. Coordination

   a. The majority of rehabilitation agencies in Northwestern Ohio serve their clients and expand their programs with little involvement in the activities of their neighbor agencies.

   b. Each rehabilitation agency in Northwestern Ohio offers some specific services and/or deals with specific types of disability groups; subsequently, most have fairly well structured eligibility requirements and systems of receiving referrals.

   c. The net results of the above two factors is that the disabled people in Northwestern Ohio are faced with fragmented, scattered and disjointed services, thus, preventing them from receiving a continuous and logical step-by-step rehabilitation.

   d. Most often, the disabled individual receives only a portion of the services he needs as most of his attending professionals are unable to direct him to a resource required to complement or supplement those services he is receiving.

4. Public Information

   a. The lack of community understanding and support of rehabilitation as a philosphy is hindering the development of the number and quality of rehabilitation programs required to serve "all in need".

   b. The medical profession is one profession in a position to coordinate and direct the delivery of rehabilitation services to the disabled; yet, unless the relevance of the rehabilitation philosphy to the tradition of medical practice is made known, the continuation of limited and restrictive medical service will continue.

   c. Employers must be informed that they are interviewing a qualified worker with a disability rather than interviewing a disabled worker.

d. The multi-faceted needs of the individual with a disability and the types of services he requires is not now a matter of public knowledge. The rehabilitation process and concept is still vague or not understood at all.

5. Finance

a. The Ohio Bureau of Vocational Rehabilitation as a purchaser of rehabilitation services for Ohio's disabled will continue to be rendered relatively ineffective unless more matching federal funds are brought into Ohio.

b. The expansion plans of the facilities, workshops and agencies in Northwestern Ohio will present competition for local, state and federal funds.

c. An orderly and coordinated approach to funding, expanding and establishing rehabilitation programs, and facilities and training rehabilitation personnel must be initiated in Northwestern Ohio.

CHAPTER

III

RECOMMENDATIONS

Chapter III: Recommendations

Recommendations will be considered under the following five categories: Facilities and Programs, Personnel, Coordination, Public Information, and Finance.

A. Facilities and Programs

1. It is recommended that consideration be immediately given to developing a comprehensive rehabilitation evaluation and treatment facility in Northwestern Ohio. Such a facility, assuming regional responsibilities, would offer the following services:

    a. Medical and vocational evaluation;
    b. Medical treatment and therapy under medical supervision;
    c. Vocational counseling;
    d. Psychometrics;
    e. Vacational training;
    f. Personal adjustment training;
    g. Vocational placement and follow-up;
    h. Training and internship of rehabilitation personnel;
    i. In-patient facilities; etc.

2. A regional rehabilitation facility must utilize "feeder" facilities throughout the 13 counties in Region 1. Consideration should be given to using local hospitals for case-finding, coordination, and limited provision of rehabilitation services.

3. Expand existing rehabilitation facilities in Northwestern Ohio to be used as teaching, evaluation and treatment centers on local bases.

4. Develop smaller and more personal institutions for the Public Offender, bringing together multi-discipline evaluation and treatment programs.

5. Develop "Half-Way Houses" for the Public Offender, Alcoholic and Drug Addict to allow gradual readjustment to the community. Within such "Houses" would be provided social, personal, and vocational adjustment counseling. From such a base would be conducted research in the environmental problems of the socially disabled.

6. Develop a residential treatment service for the emotionally disturbed adolescent.

7. Establish screening programs within school systems for the early identification of mental disabilities.

8. Develop special education programs for the emotionally disturbed.

B. Personnel

1. It is recommended that consideration be given to the formation of a training and educational center in Northwestern Ohio for the development of an adequate supply of rehabilitation manpower. Such an educational center would cooperate with institutions of higher learning in Northwestern Ohio in training professionals in such fields as rehabilitation medicine, physical therapy, occupational therapy, speech and hearing therapy, psychology, social work, vocational rehabilitation counseling, nursing, etc.

2. Because of the need for volunteers in many rehabilitation facilities and programs, educations programs for lay citizens should be initiated. Within Region I communities, schools and colleges there lies an untapped pool of workers for both direct service and public education.

3. Develop comprehensive teacher-in-service programs designed to assist teachers in meeting the emotional needs of their students. At the university level, the curriculum for elementary and secondary teachers should include courses in psychology.

4. Because of needed programs for the Socially Disabled and because of a needed change in the traditionally non-rehabilitation approach to treating the Public Offender in existing institutions, more personnel are needed with backgrounds in the behavioral **sciences.**

5. Consideration should be given to rehabilitation agencies in Northwestern Ohio sharing **scarce manpower. Mobility of personnel** for specific purposes should be explored.

C. Coordination

1. It is recommended that steps be taken to establish a regional mechanism for continued planning and coordination of rehabilitation services in Northwest Ohio. The mechanism should consist of an Advisory Committee with a full-time Executive Secretary. The problem of coordination and continued planning requires long term attention, if permanent gains are to be made. This attention can only be provided by competent full-time staff in the region.

2. The citizen interest, dialogue, and activity throughout the 13 counties in Region I must be continued by the maintenance and additional development of local Task Forces or citizen groups.

3. It is recommended that research be continued regarding the rehabilitation needs of the Physically, Mentally, and Socially Disabled. It is only with reference to facts that realistic planning and coordination of rehabilitation service can occur.

4. Because of the multi-phasic nature of their disabilities and problems, many handicapped persons are in need of more than one agency. This necessitates a smooth and effective inter-agency referral system and follow-up procedure. Such a system can be furthered and fostered by a full-time coordinating staff.

5. Steps must be taken to establish continuity of care between institutions and between institutions and the community. Among several remedies to a lack of continuity of care are (1) appointing specialists to work between agencies, clinics, institutions and the community and (2) offering to responsible agencies and individuals within the community, information on patients who are being released so that follow-up care may be continuous and specific to need; (3) assigning a full-time Ohio Bureau of Vocational Rehabilitation Counselor to each rehabilitation facility and workshop in Northwestern Ohio.

6. Dealing with the problem of the absence of interagency communication and coordination in Region I, it is recommended that all agencies prepare written definitions of their function and eligibility requirements and that a booklet containing this information be prepared for distribution to all other interested agencies and individuals.

D. Public Information

1. Develop an ongoing public relations program to tell the rehabilitation story.

2. Public education should be extended to the community, home, church, school and other areas to help the public understand some of the problems and needs of the Physically, Mentally and Socially Disabled.

3. Prepare an educational program to enumerate the rehabilitation needs of Region I, directing it simultaneously to Ohio Department of Health (for resource people), Ohio Unit of American Hospital Association (to develop the awareness of need for paramedical people, particularly medical social workers), Schools of nursing (to encourage the training in rehabilitation nursing techniques), State universities (to encourage recruitment efforts in rehabilitation fields), and State legislature (to stress legislation implementing rehabilitation rather than welfare).

4. Encourage the various voluntary health associations in Region I to become more aggressive with their public relations campaigns.

5. A mass public education program is needed to encourage the employment of the Disabled. This should be mounted through the combined efforts of all agencies involved, including the Ohio Bureau of Services for the Blind, Bureau of Vocational Rehabilitation and

Bureau of Employment Services. Civic groups, including chambers of commerce and personnel associations should also participate.

6. Serious thought should be given to changing the common terminology "handicap", which presents a negative connotation, to some more positive concept. A creative public relations firm could probably develop this idea.

E. Finance

1. Establish an Ad Hoc Committee to consider listing the Task Force Recommendations in terms of priority of need and consider means of funding and implementing them.

2. Steps should be taken to provide more State funds for use by the Ohio Bureau of Vocational Rehabilitation to serve its clients.

CHAPTER
IV

STUDY PLAN

Chapter IV: Regional Study Plan

A. General Structure

The Comprehensive evaluation of the number and needs of the Physically, Mentally and Socially Disabled in Northwestern Ohio has been directed and conducted by this area's citizens. This section of the report will describe the structure of the study, discussing the organization of the citizens into functional groups, and detailing the responsibilities, objectives and activities of these groups.

1. Regional Citizens Committee

Thirty-one citizens in planning Region I were organized into a Regional Citizens' Committee to energize, formulate, guide and review Comprehensive Planning for Vocational Rehabilitation in Northwestern Ohio. From this Citizens' Committee which first met on February 20, 1967, were established Chairmen of six Task Forces. These Task Force Chairmen comprised the Executive Committee.

2. Executive Committee

The Executive Committee explicated study objectives, established general perimeters and priorities, coordinated individual Task Force activities, monitored all study activities, reviewed progress, determined study schedules and deadlines, and gave general direction and order to the study. The Committee meetings offered and opportunity for continuous inter-checking of individual Task Force and overall study objectives to insure prevention or minimization of data gathering duplication.

3. Task Forces

The Task Forces were the functioning study groups for the Regional Citizens' Committee. Generally, the Task Force members issued questionnaires, held public hearings, made individual contacts with knowledgeable individuals throughout the Region, reviewed reports of recently completed and relevant studies, developed positions from perusals of treatises and the members' attendance at clinics and seminars, and analyzed all information regarding barriers restricting the delivery of rehabilitation services to the Physically, Mentally and Socially Disabled in Northwestern Ohio.

4. Region I Institute on Rehabilitation

On December 14, 1967, on the campus of Bowling Green University, was held an all day Institute on the Rehabilitation of the Physically, Mentally and Socially Disabled. In attendance were both lay citizens and professionals in Northwestern Ohio. In six concurrent workshops, the Institute participants described the needs of the disabled in Northwestern Ohio and, in general,

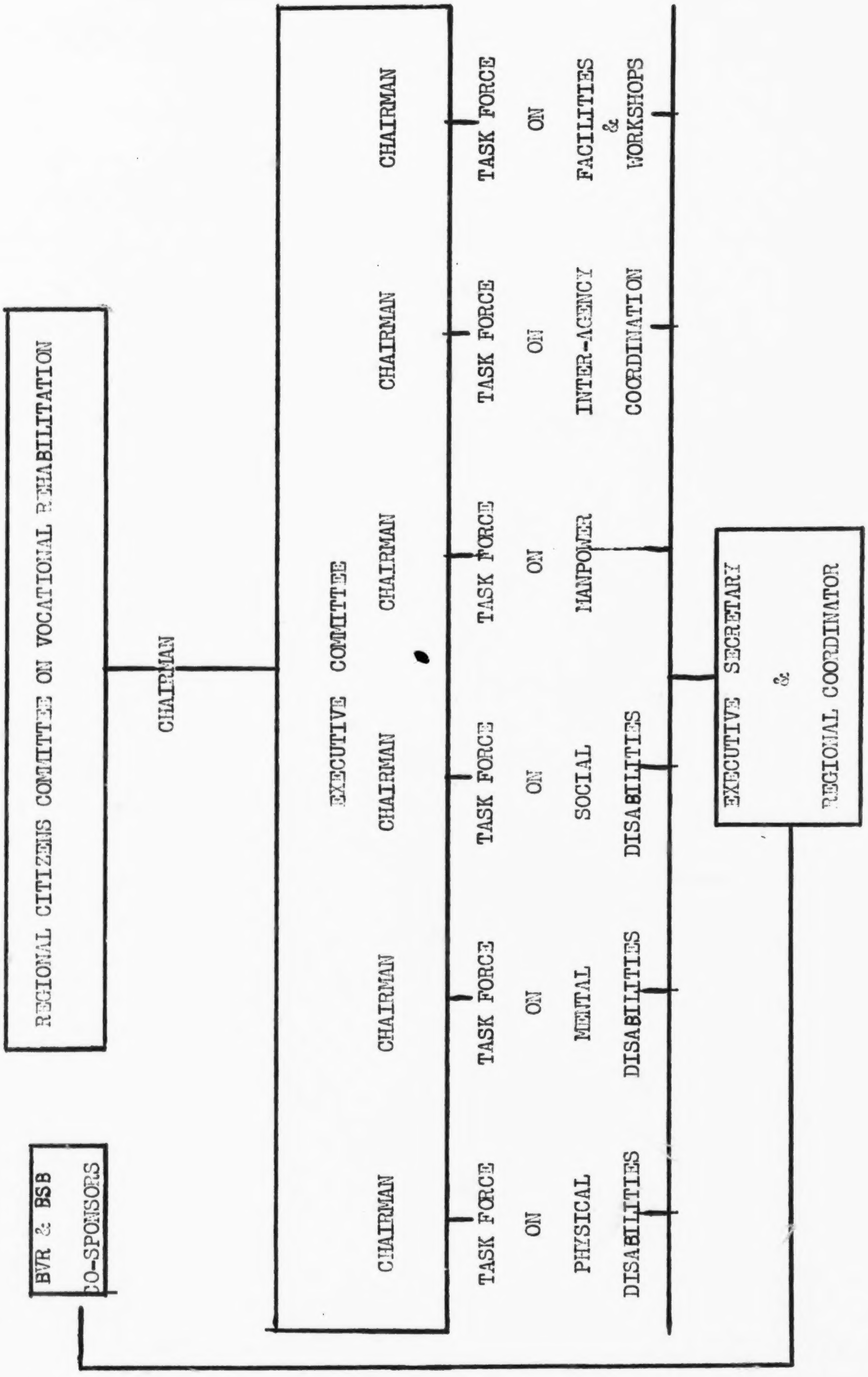

BVR & BSB
CO-SPONSORS
REGIONAL CITIZENS COMMITTEE ON VOCATIONAL REHABILITATION
CHAIRMAN
EXECUTIVE COMMITTEE
CHAIRMAN
CHAIRMAN
CHAIRMAN
CHAIRMAN
CHAIRMAN
CHAIRMAN
TASK FORCE ON PHYSICAL DISABILITIES
TASK FORCE ON MENTAL DISABILITIES
TASK FORCE ON SOCIAL DISABILITIES
TASK FORCE ON MANPOWER
TASK FORCE ON INTER-AGENCY COORDINATION
TASK FORCE ON FACILITIES & WORKSHOPS
EXECUTIVE SECRETARY & REGIONAL COORDINATOR

TABLE 7

TASK FORCE REPRESENTATION BY DISCIPLINES

Discipline	Represented in These Task Forces
Legislature	Manpower
Business & Industry	Physical Disabilities Manpower Interagency Coordination
Labor	Manpower
Medicine	Mental Disabilities Physical Disabilities Manpower Interagency Coordination
Education	Mental Disabilities Facilities & Workshops
Religion	Physical Disabilities Interagency Coordination
Courts	Social Disabilities Facilities & Workshops
Government	Social Disabilities Facilities & Workshops
Service Agencies	Physical Disabilities Social Disabilities Facilities & Workshops
Communication	Mental Disabilities

Table 8

CHRONOLOGY OF MAJOR MEETING DATES

March 6, 67	May 29,67	June 8,67	June 15,67	July 27,67	Dec 14, 67
Facilities & Workshops Task Force Organizational Meeting	Manpower Task Force Organizational Meeting	Physical Disabilities Task Force Organizational Meeting	Mental Disabilities Task Force Organizational Meeting	Executive Committee Meeting	Regional Institute

Feb 20,67	Apr 17,67	May 31,67	June 13,67	June 27,67	Nov 16,67	Jan 11,68
Regional Citizens' Committee Organizational Meeting	Executive Committee Meeting	Social Disabilities Task Force Organizational Meeting	Inter-Agency Coordination Task Force Organizational Meeting	Executive Committee Meeting	Executive Committee Meeting	*Executive Committee Meeting

Feb 29, 1968
** Final Regional Citizens' Committee Meeting

* Presentation of Reports by Task Forces

** Presentation of Regional Report to Regional Citizens' Committee provided additional definitive knowledge to be incorporated into the Regional Citizens' Committee's report to the Governor's Council on Vocational Rehabilitation. A more detailed discussion of this Institute will be included in Section V.

B. Individual Task Force Study Plans

Statewide Planning in Region I asked the following questions:

Who are in need?

What are their needs?

How are these needs presently being met?

What recommendations can be made resulting in a more satisfactory delivery of services to those in need?

The six Task Forces were formed to answer the above series of questions from two basic vantage points: the persons in need and the services offered. Three Task Forces examined the persons in need: Physical Disabilities Task Force, Mental Disabilities Task Force and Social Disabilities Task Force. Three Task Forces were generally concerned with the services offered and their development: Facilities and Workshops, Inter-agency Coordination and Manpower. The special concern of these three Task Forces were as follows.

Facilities and Workshops:

How many Facilities and Workshops are in the Region I area and where are they located?

What services do they provide?

Whom do they serve?

How may these resources be effectively deployed?

What are their expansion plans?

Inter-Agency Coordination:

What is the level of communication and cooperation that exists between the present resources delivering rehabilitation services?

How might these agencies more closely work together to serve "all in need"?

Manpower:

What are the staffing needs of the rehabilitation agencies offering services?

How might their present and future staffing needs be met?

What is the attitude of employers regarding hiring the handicapped and what can be done to encourage this practice?

1. Task Force on Physical Disabilities

   a. Orientation

   It was felt that this Task Force was concerned with the rehabilitation of people. Rehabilitation is not solely physical therapy or the provision of a brace; it is a philosophy and process encompassing every facet of the disabled one's life. Such a Task Force view of the "whole person" required the participation in this study of individuals familiar with the many sociological, psychological, economic and vocational needs associated with the various disability categories. Considering that the Task Force was concerned with the disabled in the entire Region I area, it was felt that each county should be approached and asked the following questions: "What does a handicapped individual do to your county?" What does he do for your county?" What does your county do for him?" In general, the concern of the Physical Disabilities Task Force was to view and to evaluate what is being done to rehabilitate the Physically Disabled who are handicapped in the Region I area. By "rehabilitate" is meant not only the restoration of one to his fullest economic, physical, mental, social and vocational potential, but the initial fulfillment of the same. Combined with the objective of understanding the current system of working with disabled individuals is the objective of educating responsible people to think in terms of the whole person rehabilitation process.

   b. Procedure

   Letters were issued by the Task Force to citizens (laymen and professionals in rehabilitation) in the thirteen counties in Region I, detailing the objectives of the Physical Disabilities Task Force and requesting their participation in the study and their suggestions of other possible interested citizens. Two follow-up series of letters were issued. Individuals who responded affirmatively to the letters were invited to four district seminars:

Toledo	(Lucas County)
Fremont	(Erie, Huron, Ottawa, Sandusky)
Tiffin	(Hancock, Seneca, Wood, Wyandot)
Bowling Green	(William, Defiance, Fulton, Henry)

At each seminar were represented various disciplines frequently or always involved in the rehabilitation process (e.g., physical therapists, speech therapists, vocational counselors, nurses, M.D.'s, members of voluntary health agencies, lay citizens, ministers, etc.). These professionals considered the rehabilitation needs of the physically disabled from the vantage points of their respective disciplines. They were given statistics on the estimated size of the disabled population in their communities to establish for them an awareness of the general quantitative scope of the problem at hand. They were offered the opportunity to (1) share with each other, common and unique problems in serving their disabled people; (2) arrive at a consensus regarding problems, policies, agencies and resources that should be developed to remedy these stated problems; and (3) develop a mutually shared effort towards implementation of these remedies. To establish a framework in which maximally productive discussion could occur, at each seminar were distributed work sheets to be used in listing existing services and considering needed services.

From the results of the four seminar discussions, from the completed work sheets, from positions established in the Task Force meetings and from a review of research, statistics, and recently completed relevant studies came the Task Force findings.

2. Task Force on Mental Disabilities

a. Orientation

The Mental Disability category is sub-divided into two groups: the Emotionally Disabled and the Mentally Retarded. At the first Task Force meeting, the Region I Coordinator for the State Mental Retardation Study indicated that this recently completed study concerned itself with the incidence and prevalence of the Mentally Retarded, their needs, the existing programs serving them and recommendations for programs. Considering the scope of this study and the fact that the study has reached its implementation stage the Task Force members felt that their attention and time could best be focused on the Emotionally Disabled, with the final Task Force report covering their findings and including relevant data from the Mental Retardation Study. It was further concluded that since previous studies have been global to the point of glossing over many areas of concern, this study should focus on a few major problem areas.

The Task Force was primarily concerned with educational over vocational needs, preventative over curative programs and the younger over the older age groups.

The major emphasis of this study was on the needs of children, the adolescent and the young adult in Northwestern Ohio, because this group will require the greater portion of services in the future. By 1970, close to 50 per cent of the population will be under 25 years of age.

Another reason for concentrating on the young and perhaps the most important is that if the mental health system can be programmed for the early detection of mental disorders, the prognosis for mental rehabilitation will improve considerably.

b. Procedure

The data gathering methods were essentially (1) the polling of Task Force members (12 individual contacts) and (2) the researching of existing studies on the needs of the Mentally Disabled in Northwestern Ohio. Special attention was given to the recently completed Comprehensive Mental Health and Mental Retardation Planning Project, 1963-1965. Such attention was given to avoid duplicating the activities of previous studies, yet, to include their findings where appropriate to vocational rehabilitation. A list of those studies which were consulted is found in the Appendix B.

3. Task Force on Social Disabilities

a. Orientation

There are conditions which strongly inhibit a person's ability to get and hold a job, and these conditions are not directly traced to specific physical or mental limitations. These vocationally handicapping conditions may be viewed as deriving from "Social Disabilities" and may be categorized as Alcoholism, Narcotic Addiction and Public Offense. Individuals within these categories are defined as follows.

Alcoholic - one who is habituated or addicted to overuse of alcohol.

Narcotic Addict - one who is addicted to the use of narcotics.

Public Offender - one who is now under probation or parole.

These individuals can be considered vocationally handicapped to various degrees and according to circumstances. It is a community's responsibility to determine at what point these individuals are in need of rehabilitation services and the nature of these services and, eventually, to provide these services.

b. Procedure

In order to determine the broad quantitative scope of the problem in Northwestern Ohio, (1) recently developed statistical studies were viewed regarding the estimated percentage of the population considered disabled by alcoholism and drug addiction; (2) annual reports by various agencies dealing with the Public Offender (e.g., city parole authorities, Ohio Department of Mental Hygiene and Correction, etc.) were consulted regarding incidence of incarceration and probation; and (3) professionals (judges, law enforcers, parole and probation officers) throughout Northwestern Ohio were questioned regarding their awareness of the incidence and prevalence of public offense, alcoholism and drug addiction.

To determine the quality and quantity of existing programs serving the Socially Disabled, as well as to glean recommendations for remedial programs to serve this group, questionnaires were sent to parolees and probationers, drug addicts were interviewed and discussions were held with professionals in alcoholism projects.

4. Task Force on Manpower

a. Orientation

The Task Force focused its attention on three basic points:

(1) The staffing of existing and anticipated rehabilitation facilities;

(2) The delivery of services to those in need in Region I;

(3) The hiring practices and the employment possibilities relevant to the handicapped in Region I.

b. Procedure

With the assistance of the Greater Toledo Area Hospital Planning Association staff, a questionnaire was developed and issued asking the following basic information:

(1) What is the make-up of your staff by number and discipline?

(2) What are your present and anticipated staffing needs?

(3) How do you secure and/or train your staff?

This questionnaire was sent to the forty rehabilitation resources identified by the Facilities and Workshops Task Force. Secondly, a Sub-Task Force on the Employment of the Handicapped was formed. This Sub-Task Force concerned itself with the observed lack of communication between industry and rehabilitation personnel. At its first meeting, a method of approaching the problem was developed. It was determined that one workshop at the Regional Institute on Rehabilitation would be donated to factors frustrating the employment of the handicapped. This workshop was the essential method of gathering information.

5. Task Force on Inter-Agency Coordination

   a. Orientation

   There are many excellent rehabilitation resources presently serving the Physically, Mentally and Socially Disabled in the Region I area. These services are offered in a manner fragmented by geographic and discipline separation. With continuing advances in medicine and rehabilitation yielding longer lives, yet an increase in disabilities, together with a continued developing awareness of the rehabilitation needs of the socially and mentally disabled, and increasing need is evident for concerted and cooperative applications and offerings of rehabilitation services. Fragmentary services are only as effective as the extent of communication and cooperation between the resources delivering the services allows. Thus, this Task Force was concerned not only with the quantity and quality of services provided, but also with the extent to which the agencies cross referred to each other.

   It was felt that agencies to be included in an inventory would be "those, including professional help, serving the physically, mentally and socially disabled". It was the concensus of the Task Force members that a questionnaire would be sent to these agencies soliciting comments on their referral processes, and on their services.

   b. Procedure

   A questionnaire was prepared with the assistance of the Greater Toledo Area Council of Social Agencies and was sent to representative Region I agencies. This questionnaire was also sent to the Community Chests and Councils within each County asking for the names of any rehabilitation agencies unknown to this Task Force. When the questionnaires were returned, they were reviewed and analyzed. This information was considered within the framework of concepts in interagency relationships established by this Task Force and recently completed and relevant studies.

6. Task Force on Facilities and Workshops

   a. Orientation

   A "rehabilitation facility" means a facility, operated for the primary purpose of assisting in the rehabilitation of handicapped individuals, (1) which provides one or more of the following types of services: testing, fitting or training in the use of prosthetic devices; prevocational or conditioning therapies; physical or occupational therapies, adjustment training; evaluation, treatment, or control of special disabilities; or (2) through which is provided an integrated program of medical, psychological, social, and vocational evaluation and services, under competent professional supervision: provided, that the major portion of such evaluation and services is furnished within the facility, and that all medical and related health services are prescribed by, or are under the formal supervision of, persons licensed to practice medicine or surgery in the state."

A "workshop" means a place where any manufacture of handiwork is carried on, and which is operated for the primary purpose of providing gainful employment to severely handicapped (1) as an interim step in the rehabilitation process for those who cannot be readily absorbed in the competitive labor market; or (2) during such time as employment opportunities for them in the competitive labor market do not exist.

b. Procedure

The data studied, reviewed and evaluated by this Task Force was gathered from (1) the current Ohio Bureau of Vocational Rehabilitation Five Year Study of Facilities and Workshops (specific to the thirteen counties in Statewide Planning Region I); (2) the results of a twenty-one county (including Planning Region I) survey of rehabilitation resources by one of the Task Force members; (3) personal contacts with selected facilities and workshops by Task Force researchers; and (4) a follow-up survey of expansion plans of those facilities and workshops initially contacted in the Ohio B.V.R. five year Study. This data was periodically examined and evaluated by the Task Force members. From this data and from the proceedings at the Facilities and Workshops Seminar at the Regional Institute on Rehabilitation were formulated recommendations by the Task Force.

CHAPTER V

TASK FORCE FINDINGS

Chapter V: Results of Task Force Studies

A. Task Force on Physical Disabilities

1. Findings

a. The individual with a physical disability is treated on the basis of his disability label, rather than on the basis of a comprehensive diagnosis of all of his unique needs.

b. In general, the physician in Northwestern Ohio is unaware of or unconcerned with the psychological, sociological, economic, and vocational implications of a physical disability.

c. As all or most disabled persons are initially treated by the physician, and as most physicians are unaware of or unconcerned with patients' needs beyond the medical, a great number of physically disabled are never referred to those rehabilitation oriented agencies or programs specifically designed to assist them in their psychological, sociological, economic and vocational adjustments to their communities.

d. There exists in Northwestern Ohio a shortage of rehabilitation personnel: e.g., psychiatrists, psychologists, nurses, physical and occupational therapists, social workers, vocational evaluators and counselors, etc.

e. There is a lack of communication and coordination between the above mentioned personnel in various agencies and programs; thus, the individual in need of services offered by rehabilitation agencies faces a lack of continuity in service yielding a duplication of services, or frequently no services at all.

f. Again, in referring to the lack of awareness of the rehabilitation or continuity-of-care philosophy, there exists a limited coordination of in-and-out patient services, particularly in planned discharge from hospitals, nursing homes, extended care facilities, etc.

g. There is a shortage of long term hospital beds, thus forcing those severely disabled to return to the community prior to their receiving all rehabilitation services designed to assist them in becoming as independent as possible.

h. There are these specific inadequacies in Northwestern Ohio:
   Diversional activities for the homebound;
   Vocational activities for the homebound;
   Homemaker services;
   Day care centers.

i. There is no facility in Northwestern Ohio where the physically disabled can be exposed to comprehensive evaluation and treatment of the problems imposed by the physical disability.

j. In general, there exists a lack of knowledge in all citizens of the rehabilitation concept (versus the dependency or "welfare" concept) and of community resources delivering rehabilitation services; thus, a significantly large number of disabled citizens never receive these services.

k. There exists a critical lack of educational programs to prepare health personnel (those people who usually have initial contact with individuals in need of rehabilitation services) in concepts and techniques of rehabilitation.

l. Northwestern Ohio citizens, due to their lack of understanding of the needs of the physically disabled have given little time and energy to reducing the architectural barriers which frustrate the daily routine activities of the disabled, nor have they taken significant steps in dealing with the attitudes and policies of employers and unions which restrict the hiring of the disabled.

m. Various public and private programs (e.g., Bureau of Vocational Rehabilitation) lack funds to adequately financially assist the disabled who cannot themselves purchase critically required services.

2. Implications

a. Northwestern Ohio is ignoring the practice of rehabilitation medicine which is based on these beliefs:

(1) The evaluation and management of patients with disabilities is an integral aspect of medical care;

(2) Disability can often be prevented or reduced through appropriate medical management;

(3) The goals of management include improved physical, psychological, social and vocational functioning, with or without change in the basic disease process, and such goals are a proper medical concern;

(4) A coordinated group of medical and health-related specialists under medical direction is frequently required to restore or maintain the integrated function of patients with disabilities;

(5) The mobilization of family and community resources often is an essential part of the planning and treatment process;

⑨

(6) Planning for continuity of restorative care is a medical responsibility. It is oriented toward reintegrating the patient into his social setting.

b. The concepts of rehabilitation go beyond the placing of a label on a set of signs and symptoms. There must be an assessment of the disabling effects of the disease process, the residual function and the potential for improved function. This fills a basic gap in medical practice by evincing a concern with residual health as well as the usual concern with pathologic loss. Complicated management problems are usually approached through a team effort, involving both medical and health-related personnel, emphasizing the use of the members of the team with their different skills in a concurrent inter-action, instead of having them apply their techniques one after the other and independently of each other.

c. It is difficult to analyze a community in terms of its rehabilitation potential, because concern is not with the needs of the community as a whole, but rather with the needs of the individual who is or who becomes handicapped. The ultimate problem is the total assessment of the individual's disabilities and limitations, realizing that the rehabilitation process necessitates recognizing his potentialities even when he is at his worst. Thus, his needs can be met only in terms of the resources of time, personnel, equipment, finance, facilities and agencies, to achieve his maximum capacity.

3. Conclusions

Most physical disabilities are due to chronic diseases or injuries in which impairments or deviations from normal have one or more of the following characteristics: are permanent, are caused by non-reversible pathological alteration; may be expected to require a long period of supervision, observation and care; and require special training of the patient for rehabilitation. To meet the complicated needs of long-term patients, the physician must have the help of paramedical personnel, such as nurses, physical therapists, speech therapists, occupational therapists, social workers, homemakers, health aids, etc. However, to recognize and understand the needs of the patient, he must be aware of the many varied social, emotional, and environmental factors that influence the health of his patient. He should be familiar with the health services available in the community: preventive, diagnostic, therapeutic, social and rehabilitative. He should be the captain of the team and coordinator of the services provided his patient. It is essential for the carrying out of his coordinating role that all information applicable to his patient be channeled through him regardless of the individual, agency, or institution that provides the service.

The medical care system of today has developed in response to the health service needs of the acutely ill person. However, the role of the general hospital is changing, as there is an increasing percentage of patient days being devoted to the care of the chronically ill patient. It seems very likely that this change in hospital role will continue and that there will be an increasing emphasis on the hospital as a center of comprehensive community health care. It is a place in which and from which the medical care of the community takes place. Its range of service should be as broad as possible, including prevention, diagnosis, therapy, rehabilitation, education and research. A hospital so defined in serving the community, in-patient and out-patient, will be achieving continuity of care under the medical management of the practicing physician. The concept of graduated levels of patient care (intensive, intermediate, self or ambulatory, long term and organized home care) is one way of achieving both quality and economy in health care.

Education is paramount in all levels of this discussion. It is concerned with the prevention, the reduction and the treatment of disease. It must include the patient, the public of which he is a part, and the personnel who must provide the care and services to the patient. This can only be achieved by greater communication between physicians, hospitals, health departments, voluntary agencies and clinics. Because chronic illness requires a volume of service of such complexity that they can be obtained only through some form of community coordination, planning bodies must be envisioned representing these available services to prevent overlapping as well as to fill gaps in services.

4. Recommendations

   a. Develop working committees, county-wide or section-wide, to continue the dialogue which has developed in the Task Forces, and to stimulate coordinated planning in the local community. The working committee should consist of as many representatives as possible from the disciplines functioning in every community in varying degrees. Utilize individuals who sense a personal responsibility to stimulate, prod, excite, and mobilize existing resources.

   b. Request rehabilitation medicine from the medical community, whether private physician or public health officer. Where none is available, and where there is no understanding whatsoever of the scope of rehabilitation medicine, employ outside help to stimulate awareness of the growing medical responsibilities involved. The physiatrist, or specialist in physical medicine and rehabilitation, is the only medical specialist whose training specifically encompasses the total concept of rehabilitation. Only by vocalized demands will the void be filled by attracting physicians into the field to meet the increasing needs.

c. Project the needs for regional planning into a facility serving local areas, whether hospital-based or center-oriented, to coordinate fragmented efforts now existing, and to fill the gaps which will invariably be recognized with such organization.

d. Utilize the "pilot" concept with a full-time regional or sub-regional director as a catalyst to implement the local planning in rehabilitation.

e. Expand existing rehabilitation facilities, whether medically or vocationally oriented, as teaching, evaluation and treatment centers.

f. Promote formal education for recruitment and training of rehabilitation specialists, and for research to provide for advanced and recent rehabilitation techniques and methods.

g. Disseminate specific information, whether by newspaper, letter, radio or television to the medical community, the paramedical community, the handicapped, business (the employer), legislative bodies, and to the general public.

h. Prepare a "blitz program" to enumerate rehabilitation needs, directing it simultaneously to the Ohio Department of Health (for resource people), the Ohio Unit of American Hospital Association (to develop the awareness of need for paramedical people, particularly medical social workers), schools of nursing (to encourage the training in rehabilitation nursing techniques), State universities (to encourage recruitment efforts in rehabilitation fields), and the State legislature (to stress legislation implementing rehabilitation rather than welfare).

i. Initiate a mobile team, from the State level, to visit areas where resources are limited or non-existent, to develop local efforts, or possibly to operate clinics for screening.

j. Utilization of local health departments and board for case finding, and developing working relationships and contacts with private physicians to change the concept of public health from that of welfare.

5. Report of Sub-Task Force on the Deaf

a. Procedure

A meeting was held on January 30, 1968 to determine the NEEDS of the Deaf in Region I. In attendance were: Mr. William N. Ford, Director of Special Education, Toledo Board of Education, Elm and Manhattan, Toledo, Ohio 43608;

Messrs. Vernie Colling and Vernon Browning, Vocational Rehabilitation Office, 510 Gardner Building, Toledo, Ohio 43604; Mrs. Jack Wainwright, P. H. E. A., 2927 Cheltenham Road, Toledo, Ohio 43606; and Rev. Roman G. Weltin, S.J., Chaplain for the Deaf, St. John's High School, P.O. Box 7066, R.C. Station, Toledo, Ohio 43615. Also consulted: Mrs. Donna Parker, P.H.E.A., 1744 Wilshire Blvd., Toledo, Ohio 43614; and Mrs. Carol Quick, Supervisor of Teachers of Deaf, Toledo Board of Education.

b. Findings

(1) Educational: In the Toledo area there exists a pre-school through the 12th grade program for the hearing impaired.

(a) Pre-school for 3 and 4 year old hearing impaired children is provided by the Toledo Hearing and Speech Center.

(b) There are three pre-school classes in the Public School system.

(c) Grade and High School classes in Public School use teaching by ORAL METHOD; no manual by signs or finger spelling is used.

(2) Vocational:

(a) For Deaf clients who qualify there are two Vocational Rehabilitation Counselors who communicate in Sign Language and Manual Alphabet.

(b) It has been found that time and again Deaf clients have an extreme lack of educational background.

(c) Goodwill Industries in past few years had had a training program for Deaf clients.

(d) No on-the-spot training opportunities are presently functioning.

(e) There is a lack of Diagnostic Facilities.

(f) There is no Adult Education Program for the Deaf.

c. Conclusions and Recommendations:

(1) Educational:

(a) The present grade level programs for teaching Deaf should be changed to CONTINUOUS PROGRESS, individualized instruction. This should be done not in theory but in practice. This will be the new specific design in Deaf education.

(b) Needs to Carry Out Program: Auditory equipment in Pre-school and High School levels; Teachers (present need is to get qualification of present staff). Other needs: two additional classrooms (four-five rooms will be needed within the next ten years), trained teachers and Work Study Personnel.

(2) Vocational:

(a) Local Diagnostic Facilities combined with Workshop Facilities are absolutely necessary for Region I.

(b) A "Work Experience Program" must be set up to be coordinated with the High School program.

(c) An Adult Deaf Educational Program is needed and would afford excellent opportunity for Deaf to help the Deaf.

(d) The Deaf must be included under 2nd Injury Clause of the Ohio Industrial Law.

(e) Vocational Rehabilitation Counselors specifically assigned to the Deaf should be given special consideration in case load because of amount of time involved in counseling sessions and BE FREE TO FUNCTION with other agencies and professionals involved with the Deaf. This would include closer coordination between Vocational Rehabilitation Counselors for the Deaf and the local educational facilities.

(3) General

(a) Strengthen the present mental health centers to enable the Deaf to receive adequate treatment. This will require staff members to become acquainted with the Deaf, know their problems, their weaknesses, culture, and to offer adequate service accordingly. The staff must be capable of communicating with the Deaf in the necessary language-sign or oralism. This should include private and public agencies and hospitals. Centers should be established in communities where these services are not available at the present.

(b) Community social service agencies must be available to the Deaf Communty where they can receive assistance with personal and domestic problems. Family services should be made available where difficulties exist with juvenile, martial and social problems. Here again, the staff must be capable of communicating with the Deaf, and be familiar with daily habits of the Deaf.

Agencies such as police departments, all courts, employment services, and Welfare agencies should be influenced to service the Deaf adequately. Public and private agencies must be capable of offering the same standard of services given to the Hearing Community.

(c) Authorization should be given to public day schools to teach sign language where students are unable to master oralism. The day schools and residential schools should be permitted to teach sign language where it is needed by students without forfeiture of community and State financing.

B. Mental Disabilities

1. Findings

There is a wealth of material available on the mental health needs of Ohio and Northwestern Ohio. The most recent studies are: "Final Report of the Citizens Committee, Comprehensive Community Mental Health Planning in Ohio", 1963-65; "Rehabilitation and Restoring of the Mentally and Emotionally Handicapped", June, '65; and the Lucas County Community Health Study, (Vol. 2), 1965.

Most of these reports agree on what the problem in the region is and what has to be accomplished.

Briefly, a synthesis of the above studies are reviewed with particular regard to what should be implemented in Northwestern Ohio.

1. A mental health bill should be enacted which would give more autonomy to the local communities. Regional and county mental boards should be created to coordinate these local programs.

2. Mental health professionals, including psychiatrists, psychologists, social workers and counselors should assume a leadership role within their respective communities. This would include appealing to the community for help as well as providing consultation and educational help to the community.

3. The two mental health associations should consolidate into one strong organization and thereby become more effective.

4. Salaries must be raised at all levels to keep and attract mental health professionals within Northwestern Ohio.

5. The state hospitals should work closely with the mental hygiene clinics in their areas.

6. Comprehensive Mental Health Centers should be established throughout Ohio. The Center's services would include in-patient and out-patient partial hospitalization (day and night care), community services, diagnostic services, rehabilitation services, pre-care and after-care, training and research. A comprehensive facility is being programmed for Northwestern Ohio under the provisions of Public Law 88-164, Title II for fiscal 1967.

7. The public school system should expand their emphasis on special education programs and early detection of the mentally disabled.

8. Residential care should be made available to both the mentally retarded and the emotionally disabled adolescents and children.

9. Day care programs should be initiated by both the state hospitals and the mental hygiene clinics.

10. Insurance benefits should be enlarged to cover a greater portion of the mental health costs.

11. After care and rehabilitative services must be improved.

12. A better means of accumulation and dissemination of knowledge about rehabilitation must be established.

13. State operated facilities should add more rehabilitation services for its patients.

    a. Table 9 indicates the incidence of those persons who are mentally disabled found in the thirteen county area. The table is computed by using a 1% incidence of mental disability. Persons functioning in this category are severely limited in their effectiveness because of an emotional disability and most of these should be under some form of continuous treatment. A 10% index would reflect those people who have mental disorders which interfere markedly with their functioning in the mainstream. In many cases, people who fall into this category should be hospitalized. A 1% to 3% index is used in computing the incidence of the mentally retarded depending on the age group that is being studied.

    b. A mentally retarded child can be diagnosed and evaluated in Lucas County. If a child is mildly retarded, he can attend the public schools and a slow learner class. If moderately retarded he may attain what is equivalent to a third grade education in one of three schools for the retarded in Lucas County. If the child is not ambulatory or needs 24 hour care he must leave the Region for residential care or remain with parents or relatives.

TABLE 9

INCIDENCE OF MENTAL DISABILITIES

REGION I - 1967

County		Population	Incidence of Mental Disability	Incidence of Mental Retardation
1.	Defiance	34,752	347	1,041
2.	Erie	76,876	768	2,204
3.	Fulton	31,052	310	930
4.	Hancock	59,145	591	1,773
5.	Henry	27,016	270	810
6.	Huron	51,358	513	1,539
7.	Lucas	465,209	4,652	13,956
8.	Ottawa	38,005	380	1,140
9.	Sandusky	61,476	614	1,842
10.	Seneca	62,112	621	1,863
11.	Williams	31,933	319	957
12.	Wood	80,030	800	2,400
13.	Wyandot	22,293	222	666

Once the benefit of schooling has stopped the retarded adolescent or young adult can then be referred to a sheltered workshop. The workshops in Northwestern Ohio are limited and have limited capacities. If the person cannot be placed in the workshop, the future holds little hope for a useful functioning life. If a retardate does secure work, he usually is suspect and the work is of a temporary nature.

c. If a young person has emotional problems he has a choice of treatment between a private psychiatrist or psychologist and with a therapist at a public clinic depending on the circumstances and resources of the person. If the clinic is chosen, there is a good chance that a child or adolescent specialist is not available. If there is a severe emotional problem where the young person needs residential treatment he cannot be admitted to the state hospital until he is 15. If he is admitted he will find that the hospital is not particularly programmed for young people and for the most part is treated like an adult. It should be pointed out that there are people younger than 15 who are patients at the hospital, but their admittance is predicated on unusual circumstances.

d. A female adolescent is in a better position for treatment if she needs residential care. The Luella Cummings Home treats female adolescents from age 14 to 18 who have mild emotional problems. The irony here is that almost 1/3 of the girls who are in residence are from outside Lucas County.

e. The public schools are not much help to young people with emotional problems because the bulk of their energy is directed toward maintaining facilities and staff for the normal students. It should be noted, though, that a large majority of the counseling staff in the Toledo system are still concerned with truancy and discipline instead of counseling students. At present, if a classroom teacher was trained to recognize the potential mentally disturbed child there would be no place to refer him to within the public school system. Presently, the staff and facilities for this kind of service are extremely limited.

f. There is a chance that an adolescent with an emotional problem will not graduate from high school. Emotional problems are not the cause of all dropouts, but it is a healthy contributer. Recent studies show that the median number of school years attained in Ohio is 10.9. Region I median numbers of years is about 10.9, although this figure lowers in the rural areas. The point is that the 16-18 year old adolescent has a limited choice for help if he leaves school.

g. By the time a young mentally disabled person graduates from high school, a choice is made whether to continue with school or go to work. The university offers a psychological umbrella to the student through the counseling bureau both at Bowling Green and Toledo Universities but generally severe emotional problems are not treated in these agencies. The student who chooses to work and has a disability will have more difficulty in making the adjustment to society.

2. Implications

The traditional rehabilitative approach is to assist the person after hospitalization or accident. Rehabilitation for the mentally disabled should start before hospitalization or breakdown. The rehabilitation process should concern itself with early detection and prevention as well as post-hospital therapy. There is enough research within the mental health field to support the notion that early detection and prevention, in terms of the patient's prognosis, and in terms of time and money spent on the patient, is more beneficial than waiting until the patient is hospitalized. Once hospitalized, the patient's disability is more difficult to treat in terms of restoring him to the mainstream.

3. Conclusions

a. Region I is not programmed for children, adolescents, or young adults. There are serious inadequacies with staff and facilities. There seems to be little team work between the agencies and between the professional and lay community. The region is not getting maximum output from the minimum facilities and staff that are available.

b. Concern for the mentally disabled is held by a proportionate few in Northwestern Ohio. The proportionate few are the people treating the mentally disabled or the families of the person being treated. Outside of this group there are a precious few who care about the problems of mental health.

4. Recommendations

The proposals are divided into four major areas of consideration: Communications, Systems, Staffing and Facilities.

a. Communications

(1) Local Mental Health Boards should be established to coordinate services and planning for Mental Health on a local level.

(2) The Mental Health Association should become more aggressive with their public relations campaign. This group should not hesitate to employ a public relations firm to assist them. This group should also attempt to create a

homogeniety among its members that could act as a mental health lobby not only in Northwestern Ohio but at the State level as well.

(3) There should be a greater degree of inter-agency cooperation in Region I. For the most part, each agency works alone without seeking help from others in the area. This spirit of team work would not cost the tax payer a cent yet would maximize the service given to patients and in some cases reduce the already heavy work load of the therapist.

b. Systems

(1) The school system is in a position to detect early mental disabilities. A screening system within the school system to identify youth with emotional problems should be developed.

(2) A wider availability of special education programs for the emotionally handicapped should be inaugarated.

(3) A comprehensive, enlightened, teacher-in-service program designed to assist the teacher meet the emotional needs of their respective pupils is recommended.

(4) At the university level, the curriculum for elementary and secondary teachers should include a course in abnormal psychology. The students should have the opportunity to work with the young mentally disabled at the State Hospital or similar facilities.

(5) The University Community and Technical College should finalize plans for curriculums in paramedical programs. The need is great for people to work at the para-professional level.

(6) In mental health there are esoteric words which help the professionals communicate expeditiously to each other. To a layman who for the most part lacks understanding about people with mental disabilities, the psychological lexicon deepens their anxiety about the discipline. It is recommended that in interpreting diagnosis or prognosis, especially prognosis, for the layman, the professional be careful in his choice of words. It is particularly important that the mental health worker emphasize what the patient can do and not what he cannot do for a prospective employer.

(7) General physicians, vocational rehabilitation counselors, and attorneys who work with cases involving industrial accidents and injuries should become familiar with the "Accident Process". Briefly the theory reveals that a physical injury at times results from a psychological process and the physical disturbance becomes a solution to the problems of the patient and he is unlikely to

to give up the physical illness. When chronicity supervenes, the patient seeks physicians who will not cure him and rejects others who appear capable of helping him.

The physician, counselor and attorney should be alert to this pattern and discourage the syndrome both for the best interests of the patient and for the large sums of money used to perpetuate this process.

(8) The present system of preparing patients for release back into the community is not adequate. A major weakness seems to lie in the communications between the clinic or hospital and the environment from which the patient came. The hospital or clinic physicians shouldprepare a protocol when the patient is released, and send it to the patient's family physician. Perhaps the patient's lawyer or clergyman should also be contacted.

(9) Since drug therapy is a relatively new development in the mental health field and in many cases the general practitioner is not completely briefed on the characteristics of the drugs, a series of forums should be given by psychiatrists to help the physicians better understand the drug potential.

c. Staffing

(1) There are approximately 25,000 university and college students in Region I who could relieve a part of the personnel shortage. These students could be used as psychiatric aides or in some form of therapy role. Students who are selected do not necessarily have to come from the psychology and sociology disciplines.

(2) An educational program for lay professionals should be started. The universities probably should take the initiative as far as the arrangements are concerned. It is the Task Force's understanding that Federal grants are available for these kinds of programs.

(3) If vocational rehabilitation counselors are to take on a leadership role in the community, their image must be improved. The masters degree in vocational rehabilitation should be a minimum requirement for assignment.

d. Facilities

The Task Force on Mental Disabilities asks for one facility. This facility would be for children, and young people. There is a unanimous support for this need. A strong plea is made for this facility. The following types of services should be available:

(1) A residential treatment program for both the emotionally handicapped and mentally retarded.

(2) A day care service for young people who would be under treatment during the day and return home at night.

(3) A night care service where young people could attend school during the day and return home at night.

(4) A diagnostic and evaluation service should be available at the facility. .

C. Social Disabilities: Public Offender, Alcoholic, Drug Addict

1. Findings

a. In Northwestern Ohio there are 445 adult men and women on parole; 300 located in Lucas County; nearly 75% are located in the higher population areas.

b. Statistics reveal that Northwestern Ohio has yearly contributed over 300 persons to Ohio's correctional institutions during 1964, 1965 and 1966. The largest proportion of the contribution is assumed by Lucas County.

c. Over 100 inmates in Ohio's Correctional Institutions are from Region I, with approximately 700 from Lucas County.

d. There is a high positive correlation between the use of alcohol and drugs and the committing of crime.

e. Studies indicate that 2.8% of the population may be classified as alcoholic ("those excessive drinkers whose dependence on alcohol has attained such a degree that it shows a noticeable disturbance or interference with their body or mental health, their interpersonal relations, and their satisfactory social and economic functioning" AMA); thus, there are possibly 29,720 alcoholics in Northwestern Ohio, so classified, and, in need of services.

f. Arrests and prosecutions of drug addicts in Northwestern Ohio in 1966 approximates 20, compared with 395 for the entire State of Ohio.

g. Of 37 parolees from the Adult Parole Authority Office in Toledo who responded to a questionnaire regarding the parolees' problems in adjusting to the community, the following was characteristic:

(1) A majority indicated problems in finding employment and being accepted by the community after release from correctional institutions.

(2) A majority indicated a need for vocational and personal adjustment counseling.

(3) A majority felt that the first three months of parole was most critical to successful adjustment.

(4) A majority indicated the importance of the parole officer's role in successful adjustment.

(5) The 67% recidivism rate for this sample correlates highly with the State of Ohio rate of 60%.

h. Of 33 probationers from the Toledo Municipal Court Probation Department who responded to the same questionnaire, the following was characteristic:

(1) A majority indicated that personal problems such as alcohol addiction, improper behavior, etc, frustrated successful adjustment.

(2) A majority felt a need for personal adjustment counseling to assist them in their community adjustment.

(3) Most felt that the first three months of probation are most critical to successful adjustment.

(4) Most probationers referred to the probation officer as being helpful in adjustment.

(5) A majority had more than one arrest.

i. Personal interviews with judges, probation and parole officers, and law enforcers in six of thirteen counties in Region I yielded the following observations:

(1) The more rural the community, the less critical is considered the prevalence of public offense, alcoholism and drug addiction.

(2) Throughout the Region, and especially in rural counties, the Public Offender, Alcoholic and Drug Addict is considered lazy, incorrigible and, in general, is not viewed as one with a "treatable condition" in need of rehabilitation services.

(3) It is estimated that the present scope and methods of rehabilitation has produced the following rate of success with the Drug Addict, Alcoholic and Public Offender: 5%, 10% and 40% respectively.

(4) The essential precipitating factors for becoming socially disabled are as follows: lack of a job, lack of training and education, and undesirable personality traits in relation to middle class values.

(5) There is a lack of adequately trained manpower to deal with the vocational and personal adjustment needs of the socially disabled, thus, yielding a continuation of the types of individual problems perpetuating public offense, and addiction to alcohol and drugs.

(6) Apparently, the large population centers, notably, Toledo in Lucas County, cultivate the greatest prevalence of social disabilities.

(7) The following are programs serving the Socially disabled in Region I:

Public Offender

(a) Ohio Correctional System
(b) Local parole authorities
(c) Local municipal courts
(d) Toledo House of Correction
(e) Ohio Bureau of Vocational Rehabilitation
(f) Volunteers of America
(g) Salvation Army
(h) Individual churches

Alcoholic

(a) Toledo State Hospital
(b) Toledo Department of Public Health, Alcoholism Control
(c) Sandusky City - Erie County Department of Public Health, Alcoholism Center
(d) Local Alcoholics Anonymous Organizations
(e) Volunteers of America
(f) Salvation Army
(g) Individual churches

Drug Addict

(a) No specific treatment programs.

(8) In general, the Region I community does not adopt the attitude that the committing of a crime, alcoholism and drug addiction are symptoms of underlying problems that require diagnosis and treatment - stress is still placed on punishment rather than rehabilitation.

(9) There is no coordinated effort among those Region I agencies with services of potential benefit to the socially disabled; e.g., de-toxification of the alcoholic, vocational and personal adjustment counseling, training, financial support during training, etc.

2. Implications

a. The categories, public offender, alcoholic, and drug addict, in themselves do not explicate the nature of the individuals' societal adjustment problems

b. The socially disabled can be considered vocationally handicapped to various degrees and according to individual circumstances.

c. The high recidivism rate of the public offender in Northwestern Ohio, the relatively high incidence and prevalence of alcoholism, and the low rate of success in eliminating alcoholism and drug addiction indicates that there exists unsatisfactory methods of dealing with these conditions.

d. If one assumes that underlying problems such as lack of vocational training, unemployment, personal and social maladjustment and social values lead to socially disabling conditions, it follows that the confrontation and treatment of same would reduce the conditions.

e. The Region I community is not readily adopting the understanding that the Public Offender or Alcoholic or Drug Addict cannot be routinely ignored without this encouraging continuation of underlying problems.

f. Unless programs and facilities are developed to evaluate and serve the needs of the Socially Disabled (such as assisting in the gradual absorption of the Alcoholic into the community with its stress and responsibilites) the Region I community will continue to progenerate a sizeable loss in manpower and increase in the financial burden on itself.

3. Conclusions

a. There is a need for better communication between various departments and agencies dealing with the Socially Disabled. Another bureau or coordinating body does not appear to be feasible unless it conducts an on going research and evaluation program of the existing services being offered or not being offered.

b. There exists a lack of staff and manpower in serving the Socially Disabled.

c. Smaller and more personal institutions would be of greater value than the Ohio Penitentary, Mansfield, or the other larger institutions.

d. Classification of offenders is being done on a fairly broad and cursory basis; there is a need for homogenious institutions whereby specific problems can be treated by specialists.

e. Psychiatric tools and research instruments should be developed and tested to predict social disabilities.

f. Special emphasis should be placed on motivation or remotivation by training and individual attention for the problem person.

g. More concentrated effort by all city and community planners to provide a healthy environment for the socially disabled would assist in prevention.

h. The need for a half-way house is evident to assist the disabled person in assuming responsibility in society on a gradual level of improvement.

i. Special education for the public and an attempt to reduce the general apathy and indifference to the problems of the offender is vitally needed.

4. Recommendations

a. Immediate action should be taken on behalf of the Socially Disabled.

b. More trained and educated personnel are needed to keep pace with the latest discoveries in the behaviorial science field. It is also recommended that more programs be initiated either through government fundings or local resources. Since the present system is not meeting the needs, society should allow for some trial and error and perhaps experimentation.

c. Legislative changes should be effected to provide for a more humane approach to the Socially Disabled rather than taking a vengeful or punative attitude toward the problem person.

d. Public education should be extended to the community, home, church, school and other areas to help the public understand some of the problems and needs of the offender.

e. It is recommended that those with legal responsibility for the Socially Disabled require or strongly encourage the disabled person's involvement in the community, church, special groups, clubs, social activities, etc.

f. Better community based facilities should be established and staffed. The treatment complex should be an integral part of the community with centralized services.

g. Specialists should work between agencies, clinics, the community and the institutions to provide continuity of service.

h. A further recommendation is that pressure be put on the State agencies to innovate new programs with increased competent staff and formal planning.

i. It is a final recommendation that the study of the Socially Disabled be continued with sophisticated and scientifically accurate tools.

Table 10

INMATES IN ALL OHIO ADULT CORRECTION INSTITUTIONS BY YEAR, BY COUNTY IN REGION I

COUNTY	1964	1965	1966
Defiance	25	26	21
Erie	81	74	77
Fulton	9	16	10
Hancock	29	34	33
Henry	18	18	16
Huron	27	25	27
Lucas	751	698	662
Ottawa	15	24	22
Sandusky	43	44	47
Seneca	21	27	21
Williams	13	16	20
Wood	51	49	46
Wyandot	6	11	8
Total	1,089	1,062	1,010

COURT COMMITMENTS TO ALL OHIO ADULT CORRECTION INSTITUTIONS BY YEAR, BY COUNTY IN REGION I

COUNTY	1964	1965	1966
Defiance	10	9	6
Erie	24	16	31
Fulton	4	10	3
Hancock	13	17	15
Henry	6	5	6
Huron	5	6	10
Lucas	209	167	175
Ottawa	7	15	12
Sandusky	11	19	15
Seneca	5	9	4
Williams	5	9	12
Wood	23	19	18
Wyandot	--	5	3
Total	322	306	310

D. Manpower

1. Findings - Personnel

a. The data are clear that a majority of the rehabilitation agencies are anticipating expansion. Twenty-four out of thirty agencies inventoried said "yes" when asked if they planned to expand their services in the near future. Hospitals comprised four of the six agencies who stated that no expansion was anticipated.

b. Thirteen of the agencies surveyed offered staff development programs. Significantly, sixteen of the thirty agencies, or over 50%, did not offer staff development programs. Nine of those not offering staff development programs were hospitals and seven were other types of agencies.

c. The adequacy of existing programs to educate an adequate number of professional people was seriously doubted by most of the respondents. Twenty-three of the thirty stated that in their opinion existing education programs were not adequate to train the numbers of professional persons required. Seven indicated that existing educational facilities were adequate.

d. The positions covered under the survey are listed in the appendix. At present, there are 139 budgeted but unfilled positions in the thirty agencies surveyed. The largest number of needed personnel are registered nurses and licensed practical nurses. These openings are generally in the hospitals offering rehabilitative services.

e. Other positions which are budgeted but unfilled are in a wide variety of professional skills including administrative, medical, psychology, occupational therapy, social case work, medical social work, vocational evaluation, vocational counseling, vocational teaching, therapy-aide, nurses-aide, and special education teaching.

f. The estimated number of professionals needed by 1970 by the thirty agencies surveyed is 665. Nurses, registered and licensed practical, are in greatest need, with 132 RN's needed and 106 LPN's; 131 orderlies will be required as well as 97 nurses aides. In the other allied professions, there is an estimated need for thirteen administrators, three medical directors, eleven physicians, eight psychologists, eleven occupational therapists, thirteen physical therapists, five special therapists, eight group social workers, twenty-four social workers, ten medical social workers, thirteen vocational evaluators, nine vocational counselors, seventeen vocational teachers, ten orthotists, thirteen workshop foremen and twenty-one therapy aides.

g. Interestingly, there are not enough volunteers to go around. At present the thirty agencies could use 100 and by 1970 they anticipate a need for 282.

h. Nearly all agencies indicated the need for additional personnel due to plans for expansion of services. The greatest number of agencies indicated a need for social workers and registered nurses.

i. The professional areas in which training programs are needed, according to the respondents, are registered nurses, rehabilitation nurses, psychologists, physical therapists, speech therapists, social caseworkers and licensed practical nurses.

j. The major source of staff in service training seems to be the universities in Ohio, hospitals, and special seminars and institutions. The principle sources of recruitment seem to be through professional journals and associations, with universities running a close second as a source.

Findings - Employment of the Handicapped

a. There exists a shortage of jobs for the handicapped in Region I.

b. There is a lack of effective communication between Industry (employers and unions) and professionals in the rehabilitation and employment service fields.

c. There is no centralized resource which industry can contact to make referrals for rehabilitation services and to seek information regarding the hiring of disabled workers.

d. Job securement with many major employers is primarily based on seniority, rather than on aptitude, background and physical capabilities; thus, many jobs suited to the abilities of an impaired worker are unavailable to him.

2. Implications

a. The crisis in manpower for developing rehabilitative services in Northwestern Ohio is clearly apparent from these data. The need already exists for 139 additional persons with an estimate of 665 by 1970.

b. The greatest need in numbers is for registered nurses and licensed practical nurses, with nurse aides and orderlies also in great demand. While these are mainly hospital personnel, they are a necessary and vital part of the rehabilitation team. Other positions of which there is great need are physicians, social workers, administrators and vocational counselors. The Region should not overlook the opportunity presented here for volunteers, with 100 needed now.

c. If the best use of scarce manpower in rehabilitation is to be made, considerable attention must be given at a regional level to coordination, organization and planning of a system of rehabilitative services which is closely related to the health and welfare, educational and social services systems in the Region.

3. Conclusions

a. The Task Force found that there is no coordinated approach to recruitment of health or rehabilitative personnel on the part of the agencies surveyed, or on the part of those not surveyed, who may also be providing rehabilitative services. The Task Force, therefore, concludes that some attention might be given to the development of a program for the recruitment of all health personnel with rehabilitation agencies participating in such programs. These programs should be professionally directed and supported financially in part by all health and rehabilitation agencies. (It is the opinion of the Task Force that such a function could be carried on by an overall areawide planning and coordinating organization which includes comprehensive planning for health and rehabilitative services in Northwestern Ohio).

b. Secondly, the Task Force finds that the only existing professional organization for rehabilitation workers is the Northwestern Ohio Rehabilitation Association. This organization should be encouraged to continue to grow and offer opportunities for rehabilitative workers to meet together and discuss common problems. It is the hope of the Task Force that the Northwestern Ohio Rehabilitation Association will offer its assistance in the formation of a regional areawide planning mechanism for rehabilitative services in Northwestern Ohio and serve in an advisory capacity to that group.

4. Recommendations - Personnel

a. The Task Force strongly urges that consideration be given to the formation of a training and educational center in Northwestern Ohio for the development of an adequate supply of manpower for developing rehabilitative services. It is clear that the demands are great and that existing educational institutions cannot supply that demand. The Task Force strongly recommends that the Medical College of Ohio at Toledo give consideration to this suggestion in their developing medical center.

b. The Task Force recommends that immediate steps be taken to formulate a regional planning and coordinating mechanism for rehabilitative services in cooperation with other groups forming a comprehensive health planning mechanism. The Task Force feels that coordinated planning and service development on a regional basis is essential to enable the region to make the best possible use of the most scarce commodity...manpower. It also recommends that such an agency be established in a permanent and continuing voluntary agency and that it dedicate a portion of its time to regular surveys of needs in manpower development, as well as recruitment of additional personnel. Such an agency may well dedicate some time to the planning of workshops and seminars on a regional basis for staff development in rehabilitation agencies.

c. The Task Force also recommends that each rehabilitative service and agency study the potentials for further development of continuity of patient care between and among rehabilitation agencies and the professional personnel providing the care to the patient. Further attention to this can assist in making scarce manpower more efficient. Consideration should be given to agencies sharing scarce manpower as well as to the development of written agreements between agencies offering rehabilitative services.

Recommendations - Employment of the Handicapped

a. Steps should be taken to provide more State funds for use of the Bureau of Vocational Rehabilitation to train its clients; the provision of added State funds will result in more Federal matching funds.

b. Develop a standardized definition of the term "handicapped", so that its use by the Bureau of Vocational Rehabilitation, Bureau of Employment Services and other agencies would have the same meaning.

c. A mass public education program is needed to sell the handicapped to employers. This should be mounted through the combined efforts of all agencies involved, including Bureau of Services for the Blind, Bureau of Vocational Rehabilitation and Bureau of Employment Services. Civic groups, including chambers of commerce and personnel associations should also participate.

d. A major bar to proper placement of the handicapped is the use of blanket physical examinations for all prospective employees and for all jobs. Industry and the medical profession must be encouraged to develop physical examinations that are job related. For example, a clerical job should not be judged by the same physical requirements as a press feeder job.

e. Serious thought should be given to changing the terminology from "handicap", which presents a negative connotation, to some more positive terminology. A creative public relations firm could probably develop this idea.

f. Union and management must both be approached in setting conditions for employment of the handicapped. The handicapped are denied employment because most union contracts call for seniority bidding for better jobs, with no stated provision for physical requirements. Union and management together could agree on provisions under which physical conditions related to the job bid would be a selection factor. This is closely related to recommendation #4 above.

g. General public education is needed on the new concept of the "Socially Disabled". Again, management and unions must talk together to decide on their mutual commitment in this field.

h. With respect to employment of the Socially Disabled, the employer should accept the responsibility for hiring and training this group. The training should include orientation to work, including such elements as the need for reporting to work daily and on time, the worker's relationship to his supervisor and his co-workers, and an understanding of the profit-motive in industry.

i. A governmental tax subsidy to employers who accept the responsibility for hiring and training the handicapped - including the Socially Disabled - might encourage more participation by industry.

E. Interagency Coordination

1. Findings

a. Of forty agencies in Region I receiving the Interagency Coordination Task Force Questionnaire, only eighteen responded.

b. Of the 18 questionnaires returned, 44% of the agencies did not answer the question regarding the extent of referrals they made to other agencies.

c. Of the ten agencies answering the above mentioned question, only 27% specified to which agencies it referred to clients.

d. 66% of the responding agencies had no eligibility requirements for services.

e. 77% of the responding agencies had specified methods of having clients referred to them.

f. Most of the responding agencies stated age, sex, and characteristics unique to their clientele (e.g., low I.Q., physical disability) as factors considered for eligibility of service.

g. Most of the responding agencies stated that specific people must make referrals and/or receive referrals. Little reference was made to a form that must be completed.

2. Implications

   a. Among the majority of agencies in Northwestern Ohio, there is a lack of interest in planning for a more coordinated and concerted delivery of rehabilitation services to the disabled.

   b. This lack of interest in mutual planning is evidence of each agency's primary concern with its own programs, activities, aspirations and plans.

   c. Agencies tend to communicate with each other only to a minimal degree, even when working with similar clients towards similar objectives.

   d. Agencies tend to have few eligibility restrictions beyond those obvious because of the nature of the people served.

   e. Agencies tend to have well defined methods of having clients referred to them.

3. Conclusions

   a. The Physically, Mentally and Socially Disabled in Northwestern Ohio face an uncoordinated array of rehabilitation services.

   b. Because of the lack of communication between agencies and their subsequently mutual lack of understanding of the services, eligibility standards, and the methods of referral each assumes, many disabled are denied continuous and comprehensive evaluation and treatment programs.

   c. There exists a need for a planning and coordinating mechanism to determine the structure and policies of all rehabilitation service - oriented agencies, to act as a catalyst in the development of interagency understanding and respect, to encourage more efficient utilization of existing manpower, facilities and programs, and to assume central responsibility for a coordinated delivery of rehabilitation services in Northwestern Ohio.

4. Recommendations

   a. The problem of coordination and continuing planning requires long term attention, if permanent gains are to be made. This attention can only be provided by competent full-time staff in the region.

   b. An attempt should be made to more intensively serve the handicapped and divert them to needed services and follow-up to see what, if anything, happened.

c. Cultivate and stimulate a spirit of cooperation among the agencies providing rehabilitation services. Provide committee opportunities for "give and take" relationships for both public and private agencies so that a sense of mutual cooperation, trust and respect is fostered and developed.

d. Develop and identify potential lay leadership in the field of rehabilitation. Provide an opportunity for these individuals to develop increased interest, activity and commitment to the cause of rehabilitation. This group will be a great reservoir for continued planning.

e. Ask all agencies to prepare written definitions of their function and eligibility requirements and prepare a booklet containing this information for distribution to all other agencies and individuals interested. A lack of specific information on another's service can lead to inappropriate planning, delays, duplication of effort and lost clients.

f. Because of the multiphasic nature of their disabilities or problems, many handicapped persons are in need of more than one agency. This necessitates a smooth and effective referral system and a follow-up procedure. This system can be furthered and fostered by continuing interested full-time staff.

g. Region I encompasses rural and small population areas. This presents difficult problems with respect to rehabilitation services. Lack of range in wealth and resources suggests that regional centers be established, or else community hospitals should play a more important role in regards to referral, coordination and for actual provision of rehabilitation services.

h. The committee recommends that a pamphlet, similar to the one prepared by Welfare Council of Metropolitan Chicago "Guidelines for Action in Rehabilitation", be developed for distribution as a guide to referral among the agencies, both public and private, and interested in rehabilitation.

i. If in the role of continuing planning an unmet need is revealed, it is recommended that every effort be made to add it to and include it in the service program of an existing agency, rather than develop another special agency or governmental department.

F. Facilities and Workshops

1. Findings

The findings of this Task Force are presented in the Appendixes in the form of tabled data. This tabled data is a compilation of information gathered and compiled to date.

a. Appendix 1 "Population, Incidence of Disability, Number of Rehabilitations and Number of Facilities and Workshops, by County, in Region I" shows the general population of this thirteen county area comprising Region I in Northwestern Ohio is 1,061,284. Within that total population recent studies indicate that there are 143,066 disabled individuals. It is recognized by this Task Force that the incidence of disability as reported does not necessarily mean that all of those individuals require rehabilitation services to meet their employment needs. During the last fiscal year, the Bureau of Vocational Rehabilitation rehabilitated 373 individuals in Region I. It may be noted that this report of the sixty-six existing facilities in Region I is 60 per cent complete. Thirty-eight facilities and workshops reported to date (utilizing form 31 of the coordinated Facilities and Workshops survey for the State of Ohio). Twenty-eight facilities and workshops have yet to report.

b. Appendix 2 "Geographic Location of Facilities and Workshops in Region I" is provided through the efforts of Mr. William Gregg, ex-officio to our Task Force and representing the Facilities and Workshops survey for the State. Upon receipt of this map indicating location of facilities and workshops, the committee felt that there was a possibility of three areas within Region I. Those three areas within Region I are indicated by dotted lines within the heavy black lines shown in Appendix 2. The rationale for the division into three regions is in terms of topographical accessibility. For example, Wood and Ottawa Counties may receive services rather easily by commuting to Lucas County facilities. The same is true of the other areas. It may also be noted that Williams, Fulton, Defiance and Henry Counties have a paucity of facilities and workshops offering rehabilitation services to the handicapped.

c. Appendix 3 "Sponsorship and Sponsor Property Interest in Facilities and Workshops in Region I, by County" indicates the organizations which sponsor or have sponsored the construction and the on-going programs within each facility and workshop in our Region. There is overlapping in sponsorships due to the necessity of different groups to band together to finance and operate a rehabilitation facility or workshop. It may also be stated from Appendix 3 that most sponsors own the facility or workshop which they are operating.

d. Appendix 4 "Primary Disability Groups Served During 1966 in Facilities and Workshops in Region I, by County" shows that the emphasis of the facilities and workshops in Region I is on the orthopedic and mental disabilities. As has been true of the preceding tables, the predominance of such services are in Lucas County.

e. Appendix 5 "Services by Category and County Offered in Facilities and Workshops in Region I" again indicates that the predominant services are found in Lucas County. It is interesting to note that all services for rehabilitation, as presently defined, may be found in Region I.

f. Appendix 6 shows the total clients served, BVR clients referred for service, daily caseloads and capacities for facilities and workshops and the number awaiting services. This is done by county for Region I.

g. Appendix 7 indicates the personnel employed in the facilities and workshops in Region I, by specialty and by county. Again, it may be noted that most professional personnel, employed in facilities and workshops, are found in Lucas County.

h. Appendix 8 is a report of a survey conducted by J. T. Pool, Executive Director, Betty Jane Memorial Center, Tiffin, Ohio. Mr. Pool states: "Being new to Ohio, (four months), and knowing no local, political, power and personality problems of the various communities, I feel that this report is quite creditable through far from complete.

   We have surveyed twenty-one counties of Northwestern Ohio (only 13 are included here) consisting of Williams, Fulton, Defiance, Henry, Paulding, Putnam, Van Wert, Allen, Mercer, Hardin, Auglaize, Hancock, Wood, Lucas, Ottawa, Sandusky, Seneca, Wyandot, Crawford, Huron and Erie. This area has a population of approximately one and one-half million, the largest city being Toledo with over 300,000 people, second largest being Lima with over 60,000 people.

   The area surveyed is urban and rural, in the most part, as indicated by the aforementioned figures. We have found many problems and have attempted to summarize the facilities, needs and suggestions of this survey."

   The Questionnaire and Report are followed by a county by county breakdown of the survey.

i. Appendix 9 "Survey of Future Needs of Facilities and Workshops in Region I." This follow-up survey conducted by Mr. Pool indicates that most of the 16 agencies responding (24 were contacted), the majority plan expansion in services that may be utilized for rehabilitation.

j. Appendix 10 "Information Regarding Long-Range Planning of Agencies in Region I." Mr. Gregg supplied this Task Force with portions of his survey regarding future facility and workshop planning. The selected agencies all plan future services to benefit the handicapped in our region.

2. **Implications**

a. In this Region (Northwestern Ohio), the general population is 1,061,284; according to available statistics the disabled population numbers 143,066; 373 persons were rehabilitated by the Bureau of Vocational Rehabilitation in fiscal year 1966; and 66 facilities and workshops are presently in operation.

Of the 143,066 disabled individuals in this region: 47,875 have orthopedic disabilities; 20,372 have cardiac disabilities; 17,187 have vascular disabilities; and 12,345 are reported to have digestive disabilities; the remainder have various disabilities as categorized by the National Health Survey and supplemented by the West Virginia Random Sample results of January, 1967 (Appendix). The greatest population density and subsequently the largest number of disabled individuals is found in Lucas County, which houses the city of Toledo. Various statistics exist to indicate the number, or percentage, of disabled individuals who are handicapped and require rehabilitation services. A smaller percentage require the rehabilitation services offered in rehabilitation facilities and workshops. Such percentages are vague and it is difficult to produce a meaningful figure of persons in need of facilities and workshops services.

b. Clues to the need for rehabilitation services may be found from the figures in Appendix F4. (Sixty percent of the 66 facilities and workshops served 63,974 persons in 1966); 531 persons were referred by B.V.R.; 3,671 were served daily, about 600 more than the capacity of the facilities; and 1,783 persons were on the waiting list for services. Theoretically almost 50 percent of the disabled persons needing services received them. But the question must be asked, to what extent were the services effective enough to culminate in total rehabilitation? And, were 63,974 persons completely served. In other words, did these people not only receive services, but did they receive services to the extent needed within existing facilities of this region?

c. All disability groups were served, according to data tabled in Appendix F5. (Lucas County offered services to all disability groups, but Defiance, Fulton, Henry, Ottawa, Williams, and Wyandot Counties offered no service. Presumably, those in need in those counties traveled to Toledo for service, or went without.) Even though Lucas County indicates service to major disability groups, it is an unanswered question as to whether the services were sufficient to lead to rehabilitation of the individuals concerned, and whether specific disability groups, although listed as being served, were in receipt of services designed specifically for their needs and leading to their rehabilitation.

d. Appendixes F6 and F7 list services offered and the personnel available to offer services in this Region. It is again apparent that both services and personnel are concentrated in Lucas County, with neither services nor personnel available in Defiance, Fulton, Henry, Ottawa, Williams, and Wyandot Counties. The above assumption may again hold true.

e. Appendix F9 explicates the determination on the part of regional facilities and workshops to expand in the future; basic therapies are seen in need of expansion as is expansion for in-patient services. New areas are planned: new workshops, evaluation units, dormitory facilities, classrooms, etc., in their individual efforts to meet rehabilitation demands of local clientele. Only a few indicated no expansion plans. If the facilities and workshops are planning expansion to meet demands without benefit of Statewide Planning, it appears evident that they are responding to local demands.

f. Table 12 suggests that population growth may well exceed that which was originally anticipated by 1975. If this is true, and statistics on disability are correct, the population in need of rehabilitation services will also increase by 1975.

3. Conclusions

From the preceding summary the following conclusions seem in order:

a. There exists in this region a large disabled population (based on available statistics) in terms of population and disability. It is anticipated that as the population increases so will the disabled population in need of rehabilitation services offered by facilities and workshops.

b. Presently it is not known the number of individuals who, reported as disabled, are handicapped to the extent requiring services of rehabilitation facilities and workshops.

c. It is evident that present facilities and workshops are working to capacity and that a large number of persons are awaiting services.

d. Rehabilitation services do exist in the Region. Such services are concentrated in the Toledo area, and are lacking in six of the 13 counties surveyed, and exist only basically in the other six counties.

e. There exists a paucity of trained rehabilitation personnel throughout this region including Lucas County.

f. The existing facilities and workshops are, in the main, planning expansion of services to meet local demands.

g. Although services exist there is a lack of coordination of existing services.

To express the situation briefly: rehabilitation services do exist in facilities and workshops in Region I; such services claim to serve all disability groups; services are fragmented throughout the area being concentrated in Toledo; state-federal agency personnel are limited in their scope; and all services apparently require coordination to benefit those who need them.

4. Recommendations

Recommendations of the Task Force on Facilities and Workshops fall under the general ruberics of: communication, coordination, delivery of services, and continuation of planning leading to implementation. In the main these recommendations were made at the December 14, 1967 Institute on Statewide Planning for Rehabilitation, held at Bowling Green University. They are embellished and substantiated by materials gathered and previous Task Force discussions. Responsibility for their logical development is vested in Chairman Hutchison. These recommendations are not the end, they are the beginning.

a. Communications

The rehabilitation story personified in the growth and development of facilities and workshops in Region I has not been told. The needs of individuals handicapped in our society are not known to the general public. The services of rehabilitation, designed for this small but important segment of our population, are unknown to the general public. To rectify this the following recommendations are made:

(1) Develop an on-going public relations program to tell the rehabilitation story.

(2) Centralize the functions of this group within the region, and within the State.

(3) Instruct this group to improve the image of the rehabilitation client and program.

Although the public relations effort is focused, in the preceeding remarks, on the general public there are a number of "publics" requiring similar focus:

(1) Professional Personnel

(2) Facilities and Workshops

(3) Training and Educational Institutions

(4) Public School System

(5) Industry and Business

(6) Legislators

(7) Families of Clients

Communication is lacking between agencies dedicated to the rehabilitation of handicapped persons. If an agency does not know, or recognize, the existence of another it is difficult to coordinate and focus services for handicapped people. (See 2 ff.)

b. Coordination

Coordination of existing services leading to the rehabilitation of handicapped persons is the job of the rehabilitation counselor in the Bureau of Vocational Rehabilitation (BVR). No other individual, nor agency, has the mobility or knowledge to effectively coordinate and focus rehabilitation services on an individual client. Here, too, Region I is limited by a paucity of trained personnel and operating funds. The following recommendations are made:

(1) Increase B.V.R. staff

(2) Upgrade present counselors

(3) Assign one BVR Counselor to each facility and workshop to effect coordination for rehabilitation. Such a counselor would continue on the payroll of BVR but function as a member of the facility or workshop team. The counselor is therefore in an unique position to coordinate not only the services within the facility but to reach beyond the scope of an individual facility and acquire additional rehabilitation services necessary to an individual's rehabilitation.

(4) The above may be accomplished through third party spending under the Vocational Rehabilitation Act Amendments of 1965.

Coordination of services may be further enhanced by the appointment of a BVR staff person labeled "Regional Rehabilitation Coordinator". Working directly with the present BVR staff he would have the following duties:

(1) Function as a central referral agency for all persons known to be in need of rehabilitation services.

(2) Develop and maintain a Directory of Rehabilitation Services, available to all agencies and individuals listing personnel and services within his region.

(3) Function as a clearing house for vocational placement opportunities within his region.

(4) Coordinate the agency efforts with focus on the individual.

(5) Integrate and direct rehabilitation services for individuals under the pervue of BVR, and those who do not meet the eligibility standards of BVR.

(6) Implement existing research and suggest research to agencies interested in its pursuit.

c. Continuation of Planning

Recognizing the limitations of the present Task Force report, it is recommended that planning continue.

(1) The problem of definition continues to vex professionals. It is necessary to determine the constitution of a rehabilitation facility or workshop, possibly through operational definitions in terms of services and in terms of clientele served.

(2) The lack of "hard knowledge", regarding clients, costs, personnel, services, etc., suggests that present record keeping is obsolete and that experience over a five year period of time is necessary to better determine the status of existing (and future) facilities.

(3) Working with the Task Force on Facilities and Workshops, future planning should include:

    (a) Data gathering in terms of: Services, Costs, Clientele, and Needs.

    (b) Information processing through the coordinating agency.

    (c) Definition of rehabilitation facilities and workshops.

    (d) Data contingent on agreement of agency definition.

    (e) Determination of unmet needs: external and internal.

    (f) Possibilities of expansion.

(4) Organize Facilities and Workshops regionally and on a Statewide basis. This could be done as a part of the Ohio Rehabilitation Association which has a standing committee to investigate this possibility.

d. Development of a Comprehensive Rehabilitation Facility

Accumulated data point to the need for comprehensive rehabilitation services within Region I. Presently, there exist fragmented services within the counties, services also exist beyond the regional and state boundaries. However, there is no place where a handicapped individual may receive the full range of rehabilitation services from evaluation to placement.

Toledo apparently includes all necessary rehabilitation services and most transportation routes lead there. It may be the ideal location for the development of such a center. Definitions of services to be included remain nebulous. Basically such a facility should include:

(1) Medical and Vocational Evaluation

(2) Medical Treatment and Therapy under Medical Supervision

(3) Vocational Counseling

(4) Psychometrics

(5) Vocational Training

(6) Personal Adjustment Counseling

(7) Vocational Placement and Follow-Up

(8) Training and Internship of Rehabilitation Personnel

(9) In-Patient Facilities

Such a facility, comprehensive in nature and regional in scope, could offer needed rehabilitation services to the region. It would not be a panacea, but it would be a beginning.

Total rehabilitation requires community awareness of individual problems. Without the support of a community any facility is doomed to failure. To suggest that a comprehensive rehabilitation facility be developed in Toledo presumes it will have community support. As it will serve Region I, its community becomes region-wide necessitating the development and organization of the region for its success and growth.

It appears then, that it is necessary to also decentralize some of the facility's functions. Many individuals regard a comprehensive facility as a total answer rather than assuming the necessity of providing "feeder facilities" to the comprehensive facility, and "half-way houses" for the eventual return of the individual to his home.

It is therefore recommended that facilities and workshops be developed within local communities drawing upon the services of the comprehensive facility for those aspects of rehabilitation not offered within a local community. In this manner the rehabilitation coordinator in the region could assume the responsibility to move the client to the necessary rehabilitation services and integrate the client into his home community.

CHAPTER

VI

GENERAL SUPPORTIVE DATA

Chapter VI: General Supportive Data

A. Literature - Related Studies

1. Lucas County Community Health Study (1963 - 1965).

In 1962, the National Health Commission on Community Health Services enabled twenty communities across the country to self-examine their health problems and program needs. Initiated by the Lucas County Board of Health, the Toledo Council of Social Agencies, the Academy of Medicine, the Toledo Board of Health, and the Hospital Planning Association of Greater Toledo, a movement was undertaken to establish Lucas County as a site for one of the studies. In December of 1963, under the co-sponsorship of 55 agencies and groups, and with the assistance of over 100 Lucas County citizens, the Lucas County Community Health Study commenced. The study was completed in the summer of 1965. Six sub-committees-Environmental Health I, Environmental Health II, Communicable Diseases, Chronic Diseases, Dental Diseases, and Mental Health were concerned, in general, with (1) assessing strengths and weaknesses in health services, (2) determining areas of needed improvement, (3) reporting study findings to the community, and (4) recommending future courses of action.

Of the many study recommendations, one quite relevant to this Statewide Planning Study was for the establishment of an "on going (regional) mechanism to plan and coordinate services (in the field of Health)". The Toledo Council of Social Agencies was designated as the agency to insure that this recommendation was carried out.

2. Comprehensive Health Planning and Public Health Service Act of 1966 (P.L. 89-749).

In November of 1966, P.L. 890749 was signed into law. Among other provisions, the law provides for (1) formula grants to States for comprehensive health planning at the State level through a designated State agency and (2) grants for comprehensive health planning at a local, area-wide level. In Ohio, the Ohio State Health Department has been so designated as the responsible State agency.

In August of 1967, a group of citizens met to consider comprehensive health planning in Northwestern Ohio. This meeting was in keeping with the recommendations of the above discussed Lucas County Community Health Study. The group consisted of the President of the Greater Toledo Community Chest, the presidents of the boards of the five agencies that initiated the health study and the chairmen of the Regional Medical Program (Heart, Cancer and Stroke) and Comprehensive Statewide Planning for Vocational Rehabilitation. This group met several times and, subsequently, the professionals of these respective agencies and studies have met twice to consider structuring a Regional Comprehensive Health Planning Body to assume the responsibilities described in P.L. 89-749.

3. Northwestern Ohio Regional Medical Program.

   P.L. 89-239 provides support for the development of regional medical programs for research, training, and demonstrations of patient care in heart disease, cancer, stroke and related diseases. Federal grants have been allowed for planning, feasibility studies and pilot projects. Northwestern Ohio's Regional Program (20 counties including Statewide Planning Region I)was funded effective January, 1968. The particular types of activities to be included in the regional program may include continuing medical education, equipment and staff for advanced diagnostic and treatment techniques, interchange of personnel among institutions, more effective patient referral arrangements, and increased opportunities for clinical training and research.

   The planning for total patient care includes consideration of long term care and rehabilitation. Rehabilitation considerations might include the following: Heart Disease - work evaluation programs and education of personnel in intensive care; Stroke - training of physical therapists and occupational therapists, examining need for areawide rehabilitation facilities for stroke victim; Cancer - teaching esophageal speech, teaching self-help to those who have lost bladder control, providing prostheses and ambulation training for those who have lost limbs.

   A regional Sub-Committee on Rehabilitation (chaired by the chairmen of this study's Manpower Task Force) has been established and is considering, among other points, the following: mobile rehabilitation units to visit nursing homes, a continuous survey of para-medical personnel for special skills and interests regarding heart, cancer and stroke patients, continuing education on rehabilitation, research in the rehabilitation of the amputee, rehabilitation facilities for cancer victims, work classification programs for cardiacs, etc.

   Within one year, some projects may be developed by the Regional Medical Program.

4. State of Ohio - Comprehensive Mental Health and Mental Retardation Planning Project (1963-1965).

   This two year Statewide Study on Mental Health and Mental Retardation was conducted in Northwestern Ohio (Study Region IX - twenty counties) in cooperation with the Toledo Council of Social Agencies. This study structure was quite similar to that of Comprehensive Statewide Planning for Vocational Rehabilitation. Data was collected on the existing public and private mental health and retardation facilities and programs in Northwestern Ohio, and recommendations were made to maximize effective preventative, diagnostic and treatment programs for the mentally ill and retarded.

Following the study report, the mental retardation aspect of the study moved into an implementation phase with the appointment of a full time researcher and coordinator housed with the Toledo Council of Social Agencies. This coordinator was utilized by the Mental Disabilities Task Force as a resource person.

Following the Mental Health Study recommendation for a coordinating, advisory, planning and funding body to be established on a county or multiple-county basis, the State of Ohio has directed that Mental Health Boards be established in each county to function as suggested in the Mental Health Project Report.

B. Seminar Abstracts: Region I Institute on Rehabilitation; Bowling Green, Ohio; December 14, 1967.

The purposes of this all-day Institute on the campus of Bowling Green University were(1) review Statewide Planning for Vocational Rehabilitation in Northwestern Ohio; (2) in six concurrent workshops, discuss the findings of the Task Forces and contributed additional information and observations relevant to the study's objectives; (3) consider remedies to the problems frustrating the delivery of effective and efficient rehabilitation services; and (4) discuss alternatives in implementing remedies and begin laying groundwork for implementation.

Two nationally known authorities in the field of rehabilitation discussed positions, issues, and challenges involved in a community's (local, state or national) responsibility for the rehabilitation of its handicapped citizens:

Mathew Lee, M.D., M.P.H., Assistant Professor, Clinical Rehabilitation Medicine, New York Univeristy Medical School, Goldwater Memorial Hospital, New York, New York.

(1) It is the community's responsibility to tie together all peripheral medical care services towards the goal of coordinated care of its chronically ill and disabled citizens.

(2) There exists in most communities a critical need for follow-up services after acute care.

(3) An M.D. can determine what follow-up services are required after a patient leaves the hospital; the significant question is, "Does the community have the services to fill the prescription?"

James F. Garrett, Ph. D., Assistant Commissioner, Research and Demonstration, U. S. Department of H. E. W., Social and Rehabilitation Service, Washington, D. C.

(1) The concerns of the State - Federal Rehabilitation program are expanding: Public Welfare recipients, older citizens, early diagnosis and planning for those below working age.

(2) Planning is required not only to better serve those traditionally served by rehabilitation agencies, (e.g., physically and mentally disabled), but also to determine the needs of and services for other groups (e.g., public offender, alcoholic, migrant worker).

(3) Planning, in itself, is useless; it must lead to implementation.

In six concurrent, two hour workshops, the Institute participants reviewed initial Task Force findings; and, through their reactions to these findings and their exchanges of additional observations and considerations, they produced recommendations which were incorporated into the six Task Force reports.

C. Incidence and Prevalence Information

In order to establish an understanding of the approximate size of the number in need of rehabilitation services, reference is herein made to two health surveys: (1) the National Health Survey (July, 1961-June, 1963) of non-institutionalized citizens in randomly selected households; and, (2) the West Virginia Random Sample, completed in January of 1967. The National Health Survey estimates that 12 per cent of the general population has a disability; whereas, the West Virginia Study establishes it at 14 per cent. A third study the Ohio School Census, completed in October of 1966, provided an estimate of those disabled in the age range, 5 thru 16. The following table shows a breakdown of the general disabled population by disability category.

The table can be understood as follows: of the 12 per cent of the general population estimated by the National Health Survey to be disabled, 37.6 per cent have orthopedic disabilities, 5.5 per cent are blind or have visual impairments, etc. Of the 14 per cent of the general population estimated by the West Virginia Study to be disabled, 1 per cent are blind, 18.6 per cent have cardiac conditions, etc. Of the entire Ohio school population as of October, 1966, 1 per cent have visual impairments, 1 per cent have acoustical disabilities, etc. It can be generally considered that somewhere between 12 per cent and 14 per cent of the population has some disabling condition, be it physical, mental or social.

Table 11

INCIDENCE OF PHYSICAL DISABILITIES

BVR Category	National Health Survey %	Ohio School Census %	W. Va. Random Sample Results (Jan.67) %	B.V.R. Code
Blind (legally)			1.0	10-11
Visual Impairments (other than legally blind)	5.5	0.1	5.7	12-14
Deafness (all Acoustical disabilities)	2.2	1.0	3.7	20-22
Orthopedics - Ms Cp Md, Sim. Reb. Imp.	37.6		27.9	30-39
Absence & Amputations Maj./Min. Members		0.2	2.9	40-44
Mental (Psychotic)				50
Psychoneurotic		5.0	5.0	51
Personality Disorders Alcoholism-Drug Addiction, Social Offenders	7.7			52
Mental Retardation		4.0	4.6	53
Neoplasms	2.2			60
Allergies-Endocrine Nutritional	7.4		9.4	61
Blood-Vascular	13.5		1.0	62
Epilepsy-Neurological		10.0	2.5	63
Cardiac	16.0		18.6	64
Respiratory	5.6		7.4	65
Digestive	9.7		3.1	66
Genito-Urinary	5.0		2.4	67
Speech Impairment		5.0	0.7	68
Not Elsewhere Classified			4.1	69
		25.3		

It cannot be said that all of these people are disabled to the degree that they have significant limitation of activity, or are restricted in the types of jobs they may select, or in other words, are vocationally handicapped.

Basic Data From Population Estimates for Ohio, (1-66), a publication of the Development Department of the State of Ohio, estimates the population of the thirteen county area to be 10,061,284. Table 1 displays a county breakdown of this estimate. Table 12 displays a projection of this population to 1970 and 1975.

Applying the percentages, 12 per cent and 14 per cent to Region I's population as of January, 1966, it can be roughly considered that between 127,000 and 148,000 citizens are disabled in varying degrees of severity. By 1975, the number of disabled citizens may be expanded to between 149,000 and 174,000.

In 1966, all States - Federal Vocational Rehabilitation programs across the country rehabilitated approximately 200,000 citizens. In Ohio, in 1966, 3,982 citizens were served by the Ohio Bureau of Vocational Rehabilitation; and in Region I (northwestern Ohio) 374 citizens received services from the Bureau and were assisted towards job securement. There are a substantial number of disabled citizens in Northwestern Ohio who received rehabilitation services without becoming known to the Bureau of Vocational Rehabilitation, yet as one of the major service programs working with the disabled, BVR can offer the number it serves as a meaningful indication of the total number in need being served. Comparing the 374 rehabilitated by BVR with the approximate 130,000 possibly in need of services, it is an understatement to say that only a small portion of those citizens in need of rehabilitation services are receiving them.

Table 12

REGION I

Estimated Projections of Population (in Thousands)

Age Groups	Male			Female		
	1966	1970	1975	1966	1970	1975
All Ages	521	551	610	541	575	636
Under 18	195	208	226	189	201	218
18 to 44	180	191	221	192	200	227
45 to 64	102	109	116	105	116	124
65 and over	44	44	46	54	59	64
5 to 17	131	147	155	128	142	150
18 to 24	41	60	70	48	67	78

Total population for 13 counties as of 1966 = 1,061,284

Total estimated population by 1975 = 1,246,000

CHAPTER VII

MASTER PLAN

Chapter VII: Region I Master Plan

This report has discussed the Region I Citizens' Committee's recommendations under five categories: Facilities and Programs, Personnel, Coordination, Public Information and Finance. It is the view of the Regional Citizens' Committee that a mechanism must be established to review the recommendations, order them regarding priority of importance, and design and take all steps necessary to their implementation.

A. Regional Rehabilitation Council for Implementation, Coordination and Continued Planning

It became apparent as the Task Force information was reviewed and recommendations evolved that the study activities during the past year had only uncovered a representation of specific agency and program needs. It also became apparent that agencies were planning for five to ten years in advance and that a comprehensive plan for delivering rehabilitation services that was designed this year would be outdated in five years. Consequently, the Task Force members univocally called for the continuation of studying and planning, not only that their recommendations have a vehicle for implementation , but also that the planning for and the coordination of rehabilitation services be kept a current, vital and on-going activity.

Not only would a regional mechanism assume responsibility for implementing the study proposals, it would also assume responsibility for over-all coordination in matters relating to rehabilitation in Northwest Ohio. Coordination would occur in two areas: service and planning.

1. Service

It has been revealed that a basic barrier to the effective delivery of rehabilitation services in Northwest Ohio is the lack of communication between rehabilitation agencies. There apparently exists no framework in which interagency coordination can develop and maintain itself. A regional rehabilitation planning mechanism would offer a milieu for inter-agency communication directed towards efficient utilization of rehabilitation personnel through the reduction of service duplications and gaps and towards increased inter-agency referrals, maximizing a continuous flow of services for the disabled clients.

2. Planning

The study has demonstrated a need for the development of a comprehensive rehabilitation evaluation and treatment facility. Individual Task Forces have appealed for facilities, workshops, and programs attending to the special rehabilitation needs of specific disability groups. The indicated shortage of professional rehabilitation manpower has demonstrated the need for training programs in Northwestern Ohio. The Study has revealed that many agencies in Northwestern Ohio are planning on expanding their programs and physical structures in attempts to meet the above stated needs. Unfortunately these planning activities are occuring on local levels and respond to local and immediate needs. Again, with the intention of presenting to the disabled citizens of Northwest Ohio the most effective and efficient pattern of rehabilitation services possible, it is recommended that a Regional planning mechanism be established so that by participating in such a regional planning program individual rehabilitation agencies throughout the Region can measure their relative contributions to and their roles in a system of rehabilitation services. Through continuous surveying of needs and inventorying of regional rehabilitation services, a regional rehabilitation planning mechanism could provide individual agencies with current data regarding gaps and duplications in services. Such information would be offered as guidelines for shaping individual services to maximize effective community service.

In general, a regional planning mechanism would fill an existing void: the absence of any cooperative and mutually-assisting delivery of services and planning between rehabilitation agencies in Northwestern Ohio.

B. Phase of Implementation

1. Present recommendations to the Governor's Council on Vocational Rehabilitation.

2. Encourage the Governor's Council to extend Statewide Planning activities for one year to assist the Regional Citizens' Committee as it develops a regional implementing and coordinating body.

3. Insure continuity between the activities of the Regional Citizens Committee and the mechanisms of developing a regional coordinating and implementing body by maintaining a full time staff member within Region I to work closely with the Regional Chairman and member of the Executive Committee of the Regional Citizens' Committee.

4. Immediately following an endorsement of the recommendations by the Governor's Council, establish a Region I Citizens' Ad Hoc Committee to consider (1) developing a Regional Rehabilitation Council, (2) the feasibility of appointing a full-time staff member to act as an Executive Secretary to the Council, (3) methods of funding such a staff member, (4) the functions and responsibilities of a Regional Rehabilitation Council with an Executive Secretary, (5) the most appropriate administrative base for an Executive Secretary.

CHAPTER

VIII

APPENDICES

APPENDIX A

TASK FORCE ON PHYSICAL DISABILITIES

Page

1. Regional Sub-Divisions for Physical Disabilities Task Force Meetings 85

2. B.V.R. Code - Disability Title 86

3. Physical Disabilities Work Sheet 87

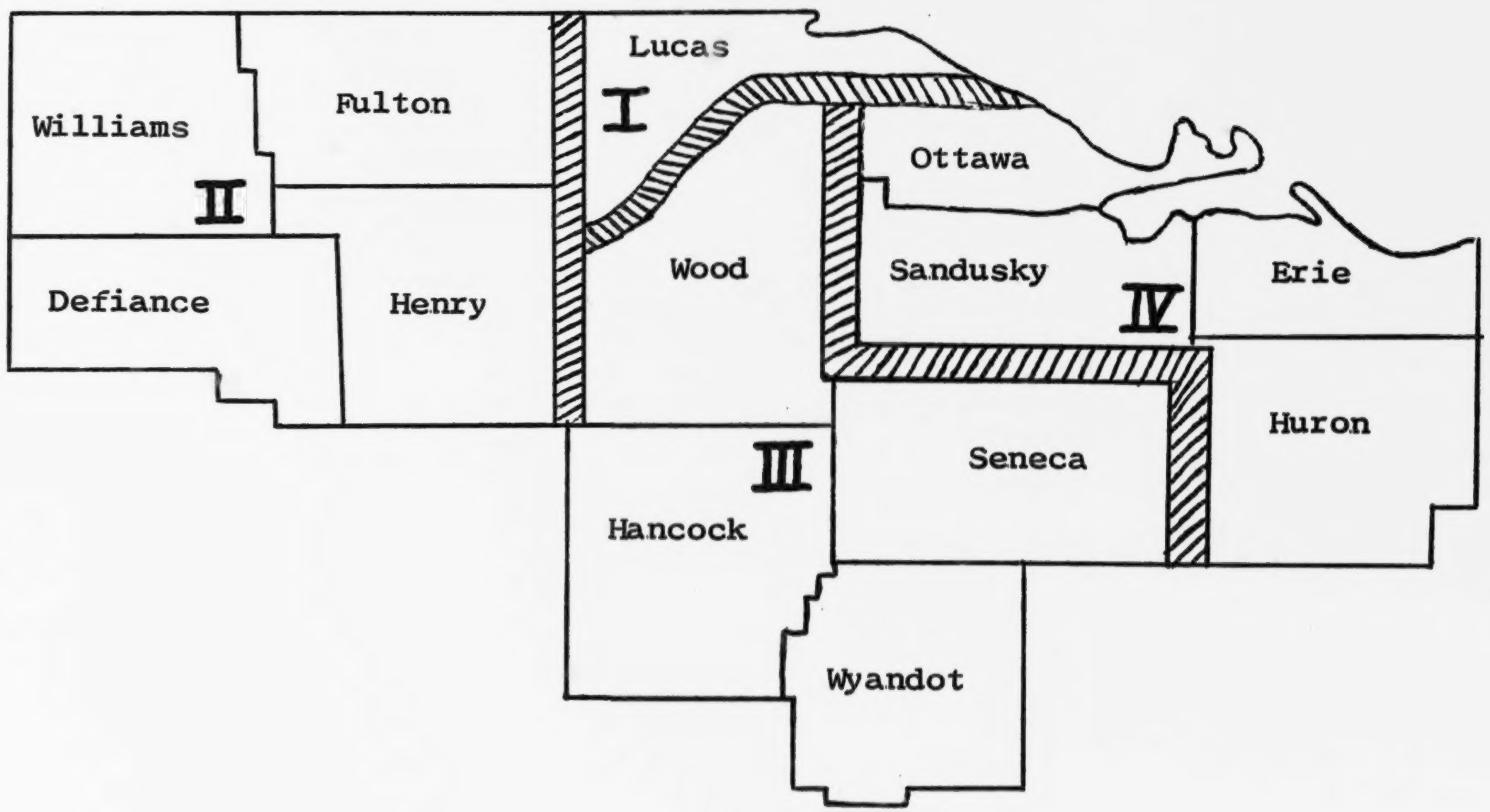
4. Task Force Formation Letter and 88
Return-Form 89

5. Incidence of Disability of B.V.R. Category and County in Region I 90-103

6. Incidence of Blindness by County in Region I 104

REGIONAL SUB-DIVISIONS FOR PHYSICAL DISABILITIES

TASK FORCE MEETINGS


Lucas
I
Williams
Fulton
II
Defiance
Henry
Ottawa
Wood
Sandusky
IV
Erie
Huron
III
Seneca
Hancock
Wyandot

BVR CODE - DISABILITY TITLE

10-11	Blind (legally)
12-14	Visual Impairments (other than legally blind)
20-22	Deafness (all acoustical disabilities)
30-39	Orthopedics-MS CP MD, Sim. Reb. Imp.
40-44	Absence & Amputations (Maj./Min. Members)
50	Mental (Psychotic)
51	Psychoneurotic
52	Personality Disorders - Alcoholism- Drug Addiction Social Offenders
53	Mental Retardation
60	Neoplasms
61	Allergies - Endocrine Nutritional - Metabolic
62	Blood-Vascular
63	Epilepsy-Neurolgical
64	Cardiac
65	Respiratory
66	Digestive
67	Genito-Urinary
68	Speech Impairment
69	Not elsewhere classified (NEC) (alphabetize)

PHYSICAL DISABILITIES WORK SHEET

	a Amputee Clinic	b Aptitude Testing	c Audiologist	d C.P. Center	e Medical Speciality	f Occupational Therapy	g Orthotic Assistance	h Out-Patient, medical	i Physical Therapy	j Prosthetic Assistance	k Psychol. Testing	l Rehab Center	m Sheltered Workshop	n Social Service	o Speech therapy/training	p Special Education	q Travel Training	r Vocational Counseling	s Work Adjustment	t Work Evaluation
10-11																				
12-14																				
20-22																				
30-39																				
40-44																				
50																				
51																				
52																				
53																				
60																				
61																				
62																				
63																				
64																				
65																				
66																				
67																				
68																				
69																				

I am writing to ask your help in completing a task which has been given us--an opportunity to discover the needs of handicapped Ohioans, and to evaluate our capacity as a State to meet these needs.

Federal legislation in 1965 made funds available to each state to conduct a two-year study of the numbers and needs of its handicapped citizens, so that all might be served by available and additional resources by 1975 or earlier. In November Governor Rhodes created the Ohio Governor's Council on Vocational Rehabilitation to assume the responsibility for a study to be completed by June 1968. The state has been divided into seven Regions, each with seven Task Forces, to examine incidence-prevalence, needs, gaps and overlaps in services to the handicapped. The Task Forces are on (1) Physical Disabilities, (2) Mental Disabilities, (3) Social Disabilities, (4) Manpower, (5) Inter-Agency Coordination, (6) Facilities and Workshops, and (7) Finance.

Region I is made up of the following counties: Defiance, Erie, Fulton, Hancock, Henry, Huron, Lucas, Ottawa, Sandusky, Seneca, Williams, Wood, and Wyandot. I am writing to you as chairman of the Task Force on Physical Disabilities for these counties, and request your participation as a representative of your respective community.

Who are the disabled of your county? What do they do to your community? What do they do for your community? What does your community provide for its disabled? These are some of the questions which must be answered for us to recognize our own needs, and to formulate plans to provide an increased understanding of the benefits of rehabilitation. We may then implement our resources to reach the maximum number of those who have the needs. Active participation of community members in conducting the study and designing the plan will generate the dedication and action necessary to carry out the program.

Because of the large area to be studied, we will conduct key local area meetings in establishing County Task Forces to gather data on a community level and to make recommendations in terms of local needs.

Thank you for your consideration of this challenge. We are looking forward to time well spent in a worthwhile endeavor.

Sincerely yours,

Robert J. Gosling, M.D.,
Chairman, Task Force on
Physical Disabilities

Please return this slip to:

Robert J. Gosling, M.D.
Chairman, Task Force on Physical Disabilities
3939 Monroe Street
Toledo, Ohio 43613

I am interested in discovering my own community's needs. Yes___ No___
I am aware of my community's needs. Yes___ No___
I will be able to help in some way in the study which is being planned at this time. Yes___ No___

Signed______________________________

Address______________________________

The following people, lay or professional, are citizens of our area who are interested in, work with, or are aware of the problems of the physically handicapped. They might be interested in participating in this study.

1. ____

2. ____

3. ____

4. ____

5. ____

6. ____

7. ____

8. ____

9. ____

10. ____

(Please include the address of these people.)

Thank you again,
RJG.

Table 2: Incidence of Disability by BVR Category in Region I

Total Population: 1,061,284
Total Public School Population: 237,326

BVR Category	National Health Survey	Ohio School Census	W. Va. Survey (trial)	W. Va. Random Sample Results (Jan. 67)	BVR Code
Blind (legally)	6,997	230	8,907	1,479	10-11
Visual Impairments (other than legally blind)				8,460	12-14
Deafness (all acoustical disabilities)	2,794	2,367	5,936	5,491	20-22
Orthopedics-MS CF MD, Sim. Reb. Imp.	47,875	469	42,337	41,447	30-39
Absence & Amputations (Maj./Min. members)	----		----	4,303	40-44
Mental (Psychotic)	9,800	11,871	13,285	7,417	50
Psychoneurotic			----		51
Personality Disorders Alcoholism-Drug Addiction, Social Offenders			----		52
Mental Retardation		9,497	13,365	6,825	53
Neoplasms	2,794	----	----	13,961	60
Allergies-Endocrine-Nutritional-Metabolic	9,416	----	4,455		61
Blood-Vascular	17,187	----	----	1,497	62
Epilepsy-Neurological	----	23,723	4,153	3,710	63
Cardiac	20,372	----	21,388	27,627	64
Respiratory	7,124	----	14,109	10,987	65
Digestive	12,345	----	4,450	4,597	66
Genito-Urinary	6,362	----		3,558	67
Speech Impairment	----	11,871	----	1,034	68
Not Elsewhere classified	----	----	----	6,086	69
Totals	143,066	60,028	132,385	148,479	

County: Defiance
Population: 34,750 (1/1/66)
Public School Population: 8,658 (10/66)

BVR Category	National Health Survey		Ohio School Census		W. Va. Survey (trial)		W. Va. Random Sample Results (Jan. 67)		BVR Code
	%	No.	%	No.	%	No.	%	No.	
Blind (legally)							1.0	48.	10-11
Visual Impairments (other than legally blind)	5.5	229.	0.1	8.	6.0	291.	5.7	277.	12-14
Deafness (all acoustical disabilities	2.2	91.	1.0	86.	4.0	194.	3.7	180.	20-22
Orthopedics-MS CP MD, Sim. Reb. Imp.	37.6	1567.			28.5	1386.	27.9	1357.	30-39
Absence & Amputations (Maj./Min. members)			0.2	17.			2.9	141.	40-44
Mental (Psychotic)					9.0	437.			50
Psychoneurotic			5.0	432.			5.0	243.	51
Personality Disorders Alcoholism-Drug Addiction, Social Offenders	7.7	321.							52
Mental Retardation			4.0	346.	9.0	437.	4.6	223.	53
Neoplasms	2.2	91.							60
Allergies-Endocrine-Nutritional-Metebolic	7.4	308.			3.0	145.	9.4	457.	61
Blood-Vascular	13.5	562.					1.0	48.	62
Epilepsy-Neurological			10.0	865	2.8	136.	2.5	121.	63
Cardiac	16.0	667.			14.4	700.	18.6	904.	64
Respiratory	5.6	233.			9.5	462.	7.4	360.	65
Digestive	9.7	404.					3.1	150.	66
Genito-Urinary	5.0	208.			3.0	145.	2.4	116.	67
Speech Impairment			5.0	432.			0.7	34.	68
Not elsewhere classified (NEC)							4.1	199.	69

County: Erie
Population: 76,876 (1/1/66)
Public School Population: 18,500 (10/66)

BVR Category	National Health Survey		Ohio School Census		W. Va. Survey (trial)		W. Va. Random Sample Results (Jan. 67)		BVR Code
	%	No.	%	No.	%	No.	%	No.	
Blind (legally)	5.5	507	0.1	18	6.0	645	1.0	107	10-11
Visual Impairments (other than legally blind)							5.7	613	12-14
Deafness (all acoustical disabilities	2.2	202	1.0	185	4.0	430	3.7	398	20-22
Orthopedics-MS CP MD, Sim. Reb. Imp.	37.6	3468	0.2	37	28.5	3067	27.9	3002	30-39
Absence & Amputations (Maj./Min. members)							2.9	312	40-44
Mental (Psychotic)	7.7	710	5.0	925	9.0	968	5.0	530	50
Psychoneurotic									51
Personality Disorders Alcoholism-Drug Addiction, Social Offenders									52
Mental Retardation			4.0	740	9.0	968	4.6	495	53
Neoplasms	2.2	202					9.4	1011	60
Allergies-Endocrine-Nutritional-Metabolic	7.4	682			3.0	322			61
Blood-Vascular	13.5	1245					1.0	107	62
Epilepsy-Neurological			10.0	1850	2.8	301	2.5	269	63
Cardiac	16.0	1476			14.4	1549	18.6	2001	64
Respiratory	5.6	516			9.5	1022	7.4	796	65
Digestive	9.7	894			3.0	322	3.1	333	66
Genito-Urinary	5.0	461					2.4	258	67
Speech Impairment			5.0	925			0.7	75	68
Not elsewhere classified (NEC)							4.1	441	69

Appendix 2.2

24.

County: Fulton
Population: 31,051 (1/1/66)
Public School Population: 9,659 (10/66)

BVR Category	National Health Survey		Ohio School Census		W. Va. Survey (trial)		W. Va. Random Sample Results (Jan. 67)		BVR Code
	%	No.	%	No.	%	No.	%	No.	
Blind (legally)	5.5	204	0.1	9	6.0	260	1.0	43	10-11
Visual Impairments (other than legally blind)							5.7	247	12-14
Deafness (all acoustical disabilities	2.2	81	1.0	96	4.0	173	3.7	160	20-22
Orthopedics-MS CP MD, Sim. Reb. Imp.	37.6	1401	0.2	19	28.5	1238	27.9	1212	30-39
Absence & Amputations (Maj./Min. members)							2.9	126	40-44
Mental (Psychotic)	7.7	286	5.0	482	9.0	391	5.0	217	50
Psychoneurotic									51
Personality Disorders Alcoholism-Drug Addiction, Social Offenders									52
Mental Retardation			4.0	386	9.0	391	4.6	199	53
Neoplasms	2.2	81					9.4	408	60
Allergies-Endocrine Nutritional-Metabolic	7.4	275			3.0	130			61
Blood-Vascular	13.5	503					1.0	43	62
Epilepsy-Neurological			10.0	965	2.8	121	2.5	108	63
Cardiac	16.0	596			14.4	625	18.6	808	64
Respiratory	5.6	208			9.5	412	7.4	321	65
Digestive	9.7	361			3.0	130	3.1	134	66
Genito-Urinary	5.0	186					2.4	104	67
Speech Impairment			5.0	482			0.7	30	68
Not elsewhere classified (NEC)							4.1	178	69

Appendix 2.4

County: Hancock
Population: 59,145 (1/1/66)
Public School Population: 13,560 (10/66)

BVR Category	National Health Survey		Ohio School Census		W. Va. Survey (trial)		W. Va. Random Sample Results (Jan. 67)		BVR Code
	%	No.	%	No.	%	No.	%	No.	
Blind (legally)	5.5	390	0.1	13	6.0	496	1.0	82	10-11
Visual Impairments (other than legally blind)							5.7	471	12-14
Deafness (all acoustical disabilities	2.2	156	1.0	35	4.0	331	3.7	306	20-22
Orthopedics-MS CP MD, Sim. Reb. Imp.	37.6	2668	0.2	27	28.5	2359	27.9	2310	30-39
Absence & Amputations (Maj./Min. members)							2.9	240	40-44
Mental (Psychotic)	7.7	546	5.0	679	9.0	745	5.0	414	50
Psychoneurotic									51
Personality Disorders Alcoholism-Drug Addiction, Social Offenders									52
Mental Retardation			4.0	543	9.0	745	4.6	380	53
Neoplasms	2.2	156					9.4	778	60
Allergies-Endocrine Nutritional-Metabolic	7.4	525			3.0	248			61
Blood-Vascular	13.5	958					1.0	82	62
Epilepsy-Neurological			10.0	1358	2.8	231	2.5	207	63
Cardiac	16.0	1135			14.4	1192	18.6	1540	64
Respiratory	5.6	397			9.5	786	7.4	612	65
Digestive	9.7	688			3.0	248	3.1	256	66
Genito-Urinary	5.0	354					2.4	198	67
Speech Impairment			5.0	679			0.7	57	68
Not elsewhere classified (NEC)							4.1	339	69

County: Henry
Population: 27,016 (1/1/66)
Public School Population: 6,887 (10/66)

BVR Category	National Health Survey		Ohio School Census		W. Va. Survey (trial)		W. Va. Random Sample Results (Jan. 67)		BVR Code
	%	No.	%	No.	%	No.	%	No.	
Blind (legally)	5.5	178	0.1	6	6.0	226	1.0	37	10-11
Visual Impairments (other than legally blind)							5.7	215	12-14
Deafness (all acoustical disabilities	2.2	71	1.0	68	4.0	151	3.7	139	20-22
Orthopedics-MS CP MD, Sim. Reb. Imp.	37.6	1218	0.2	13	28.5	1077	27.9	1055	30-39
Absence & Amputations (Maj./Min. members)							2.9	109	40-44
Mental (Psychotic)	7.7	249	5.0	344	9.0	340	5.0	189	50
Psychoneurotic									51
Personality Disorders Alcoholism-Drug Addiction, Social Offenders									52
Mental Retardation			4.0	275	9.0	340	4.6	173	53
Neoplasms	2.2	71					9.4	355	60
Allergies-Endocrine Nutritional-Metabolic	7.4	239			3.0	113			61
Blood-Vascular	13.5	437					1.0	37	62
Epilepsy-Neurological			10.0	668	2.8	105	2.5	94	63
Cardiac	16.0	518			14.4	544	18.6	703	64
Respiratory	5.6	181			9.5	359	7.4	279	65
Digestive	9.7	314			3.0	113	3.1	117	66
Genito-Urinary	5.0	162					2.4	90	67
Speech Impairment			5.0	344			0.7	26	68
Not elsewhere classified (NEC)							4.1	155	69

Appendix 2.6

County: Huron
Population: 51,358 (1/1/66)
Public School Population: 12,811 (10/66)

BVR Category	National Health Survey		Ohio School Census		W. Va. Survey (trial)		W. Va. Random Sample Results (Jan. 67)		BVR Code
	%	No.	%	No.	%	No.	%	No.	
Blind (legally)	5.5	338	0.1	12	6.0	431	1.0	71	10-11
Visual Impairments (other than legally blind)							5.7	409	12-14
Deafness (all acoustical disabilities	2.2	135	1.0	128	4.0	287	3.7	266	20-22
Orthopedics-MS CP MD, Sim. Reb. Imp.	37.6	2317	0.2	25	28.5	2049	27.9	2006	30-39
Absence & Amputations (Maj./Min. members)							2.9	208	40-44
Mental (Psychotic)	7.7	474	5.0	640	9.0	647	5.0	359	50
Psychoneurotic									51
Personality disorders Alcoholism-Drug Addiction, Social Offenders									52
Mental Retardation			4.0	512	9.0	647	4.6	330	53
Neoplasms	2.2	135					9.4	675	60
Allergies-Endocrine-Nutritional-Metabolic	7.4	456			3.0	215			61
Blood-Vascular	13.5	831					1.0	71	62
Epilepsy-Neurological			10.0	1281	2.8	201	2.5	179	63
Cardiac	16.0	986			14.4	1035	18.6	1337	64
Respiratory	5.6	345			9.5	683	7.4	532	65
Digestive	9.7	597			3.0	215	3.1	222	66
Genito-Urinary	5.0	308					2.4	172	67
Speech Impairment			5.0	640			0.7	50	68
Not elsewhere classified (NEC)							4.1	294	69

Appendix 2.7

County: Lucas
Population: 465,209 (1/1/66)
Public School Population: 98660 (10/66)

BVR Category	National Health Survey		Ohio School Census		W. Va. Survey (trial)		W. Va. Random Sample Results (Jan. 67)		BVR Code
	%	No.	%	No.	%	No.	%	No.	
Blind (legally)	5.5	3202	0.1	98	6.0	4075	1.0	679	10-11
Visual Impairments (other than legally blind)							5.7	3871	12-14
Deafness (all acoustical disabilities)	2.2	1280	1.0	988	4.0	2717	3.7	2513	20-22
Orthopedics-MS CP MD, Sim. Reb. Imp.	37.6	21892	0.2	197	28.5	19359	27.9	18952	30-39
Absence & Amputations (Maj./Min. members)							2.9	1969	40-44
Mental (Psychotic)	7.7	4483	5.0	4943	9.0	6113	5.0	3396	50
Psychoneurotic									51
Personality disorders Alcoholism-Drug Addiction, Social Offenders									52
Mental Retardation			4.0	3954	9.0	6113	4.6	3124	53
Neoplasms	2.2	1280							60
Allergies-Endocrine-Nutritional-Metabolic	7.4	4308			3.0	2037	9.4	6385	61
Blood-Vascular	13.5	7860					1.0	697	62
Epilepsy-Neurological			10.0	9886	2.8	1902	2.5	1698	63
Cardiac	16.0	9316			14.4	9781	18.6	12634	64
Respiratory	5.6	3260			9.5	6453	7.4	5026	65
Digestive	9.7	5647			3.0	2037	3.1	2105	66
Genito-Urinary	5.0	2911					2.4	1630	67
Speech Impairment			5.0	4943			0.7	475	68
Not elsewhere classified (NEC)							4.1	2785	69

County: Ottawa
Population: 38,009 (1/1/66)
Public School Population: 9,437 (10/66)

BVR Category	National Health Survey %	National Health Survey No.	Ohio School Census %	Ohio School Census No.	W. Va. Survey (trial) %	W. Va. Survey (trial) No.	W. Va. Random Sample Results (Jan. 67) %	W. Va. Random Sample Results (Jan. 67) No.	BVR Code
Blind (legally)	5.5	250	0.1	9	6.0	319	1.0	53	10-11
Visual Impairments (other than legally blind)							5.7	303	12-14
Deafness (all acoustical disabilities)	2.2	100	1.0	94	4.0	212	3.7	196	20-22
Orthopedics-MS CP MD, Sim. Reb. Imp.	37.6	1714	0.2	18	28.5	1516	27.9	1484	30-39
Absence & Amputations (Maj./Min. members)							2.9	154	40-44
Mental (Psychotic)	7.7	351	5.0	471	9.0	478	5.0	266	50
Psychoneurotic									51
Personality disorders Alcoholism-Drug Addiction, Social Offenders									52
Mental Retardation			4.0	377	9.0	478	4.6	244	53
Neoplasms	2.2	100					9.4	500	60
Allergies-Endocrine-Nutritional Metabolic	7.4	337			3.0	159			61
Blood-Vascular	13.5	615					1.0	53	62
Epilepsy-Neurological			10.0	943	2.8	148	2.5	133	63
Cardiac	16.0	729			14.4	766	18.6	989	64
Respiratory	5.6	255			9.5	505	7.4	393	65
Digestive	9.7	442			3.0	159	3.1	164	66
Genito-Urinary	5.0	228					2.4	127	67
Speech Impairment			5.0	471			0.7	37	68
Not elsewhere classified (NEC)							4.1	218	69

Appendix 2.9

County: Sandusky
Population: 61,476 (1/1/66)
Public School Population: 14,538 (10/66)

BVR Category	National Health Survey %	National Health Survey No.	Ohio School Census %	Ohio School Census No.	W. Va. Survey (trial) %	W. Va. Survey (trial) No.	W. Va. Random Sample Results (Jan. 67) %	W. Va. Random Sample Results (Jan. 67) No.	BVR Code
Blind (legally)	5.5	405	0.1	14	6.0	516	1.0	86	10-11
Visual Impairments (other than legally blind)							5.7	490	12-14
Deafness (all acoustical disabilities)	2.2	162	1.0	145	4.0	344	3.7	318	20-22
Orthopedics-MS CP MD, Sim. Reb. Imp.	37.6	2773	0.2	29	28.5	2452	27.9	2401	30-39
Absence & Amputations (Maj./Min. members)							2.9	249	40-44
Mental (Psychotic)	7.7	568	5.0	726	9.0	774	5.0	430	50
Psychoneurotic									51
Personality disorders Alcoholism-Drug addiction, Social Offenders									52
Mental Retardation			4.0	581	9.0	774	4.6	395	53
Neoplasms	2.2	162					9.4	809	60
Allergies-Endocrine-Nutritional-Metabolic	7.4	545			3.0	258			61
Blood-Vascular	13.5	996					1.0	86	62
Epilepsy-Neurological			10.0	1453	2.8	240	2.5	215	63
Cardiac	16.0	1180			14.4	1239	18.6	1600	64
Respiratory	5.6	413			9.5	817	7.4	636	65
Digestive	9.7	715			3.0	258	3.1	266	66
Genito-Urinary	5.0	368					2.4	206	67
Speech Impairment			5.0	726			0.7	60	68
Not elsewhere classified (NEC)							4.1	352	69

County: Seneca
Population: 62,111 (1/1/66)
Public School Population: 13,318 (10/66)

BVR Category	National Health Survey		Ohio School Census		W. Va. Survey (trial)		W. Va. Random Sample Results (Jan. 67)		BVR Code
	%	No.	%	No.	%	No.	%	No.	
Blind (legally)	5.5	409	0.1	13	6.0	521	1.0	86	10-11
Visual Impairments (other than legally blind)							5.7	495	12-14
Deafness (all acoustical disabilities)	2.2	163	1.0	133	4.0	347	3.7	321	20-22
Orthopedics-MS CP MD, Sim. Reb. Imp.	37.6	2802	0.2	26	28.5	2478	27.9	2426	30-39
Absence & Amputations (Maj./Min. members)							2.9	252	40-44
Mental (Psychotic)	7.7	573	5.0	665	9.0	702	5.0	434	50
Psychoneurotic									51
Personality disorders Alcoholism-Drug Addiction, Social Offenders									52
Mental Retardation			4.0	532	9.0	782	4.6	399	53
Neoplasms	2.2	163					9.4	817	60
Allergies-Endocrine-Nutritional-Metabolic	7.4	551			3.0	260			61
Blood-Vascular	13.5	1006					1.0	86	62
Epilepsy-Neurological			10.0	1331	2.8	243	2.5	217	63
Cardiac	16.0	1192			14.4	1252	18.6	1617	64
Respiratory	5.6	417			9.5	826	7.4	643	65
Digestive	9.7	722			3.0	260	3.1	269	66
Genito-Urinary	5.0	372					2.4	208	67
Speech Impairment			5.0	665			0.7	60	68
Not elsewhere classified (NEC)							4.1	356	69

County: Williams
Population: 31,933 (1-1-66)
Public School Population: 8,182 (10-66)

BVR Category	National Health Survey		Ohio School Census		W. Va. Survey (trial)		W. Va. Random Sample Results (Jan. 67)		BVR Code
	%	No.	%	No.	%	No.	%	No.	
Blind (legally)	5.5	210	0.1	8	6.0	268	1.0	44	10-11
Visual Impairments (other than legally blind)							5.7	254	12-14
Deafness (all acoustical disabilities)	2.2	84	1.0	81	4.0	178	3.7	165	20-22
Orthopedics-MS CP MD, Sim. Reb. Imp.	37.6	1440	0.2	16	28.5	1274	27.9	1247	30-39
Absence & Amputations (Maj./Min. members)							2.9	129	40-44
Mental (Psychotic)	7.7	295	5.0	409	9.0	402	5.0	223	50
Psychoneurotic									51
Personality disorders Alcoholism-Drug Addiction, Social Offenders									52
Mental Retardation			4.0	327	9.0	402	4.6	205	53
Neoplasms	2.2	84					9.4	420	60
Allergies-Endocrine-Nutritional-Metabolic	7.4	283			3.0	134			61
Blood-Vascular	13.5	517					1.0	44	62
Epilepsy-Neurological			10.0	812	2.8	125	2.5	111	63
Cardiac	16.0	613			14.4	643	18.6	831	64
Respiratory	5.6	214			9.5	424	7.4	330	65
Digestive	9.7	371			3.0	134	3.1	138	66
Genito-Urinary	5.0	191					2.4	107	67
Speech Impairment			5.0	409			0.7	31	68
Not elsewhere classified (NEC)							4.1	183	69

Appendix 2.12

County: Wood
Population: 80,030 (1/1/66)
Public School Population: 17,976 (10/66)

BVR Category	National Health Survey %	National Health Survey No.	Ohio School Census %	Ohio School Census No.	W. Va. Survey (trial) %	W. Va. Survey (trial) No.	W. Va. Random Sample Results (Jan. 67) %	W. Va. Random Sample Results (Jan. 67) No.	BVR Code
Blind (legally)	5.5	528	0.1	17	6.0	672	1.0	112	10-11
Visual Impairments (other than legally blind)							5.7	638	12-14
Deafness (all acoustical disabilities)	2.2	211	1.0	179	4.0	448	3.7	414	20-22
Orthopedics-MS CP MD, Sim. Reb. Imp.	37.6	3610	0.2	35	28.5	3193	27.9	3125	30-39
Absence & Amputations (Maj./Min. members)							2.9	324	40-44
Mental (Psychotic)	7.7	739	5.0	898	9.0	1008	5.0	560	50
Psychoneurotic									51
Personality disorders Alcoholism-Drug Addiction, Social Offenders									52
Mental Retardation			4.0	719	9.0	1008	4.6	515	53
Neoplasms	2.2	211					9.4	1053	60
Allergies-Endocrine-Nutritional-Metabolic	7.4	710			3.0	336			61
Blood-Vascular	13.5	1296					1.0	112	62
Epilepsy-Neurological			10.0	1797	2.8	313	2.5	280	63
Cardiac	16.0	1536			14.4	1613	18.6	2083	64
Respiratory	5.6	536			9.5	1064	7.4	829	65
Digestive	9.7	931			3.0	336	3.1	347	66
Genito-Urinary	5.0	480					2.4	268	67
Speech Impairment			5.0	898			0.7	78	68
Not elsewhere classified (NEC)							4.1	459	69

County: Wyandot
Population: 22,293 (1/1/66)
Public School Population: 5,140 (10/66)

BVR Category	National Health Survey		Ohio School Census		W. Va. Survey (trial)		W. Va. Random Sample Results (Jan. 67)		BVR Code
	%	No.	%	No.	%	No.	%	No.	
Blind (legally)	5.5	147	0.1	5	6.0	187	1.0	31	10-11
Visual Impairments (other than legally blind)							5.7	177	12-14
Deafness (all acoustical disabilities)	2.2	58	1.0	51	4.0	124	3.7	115	20-22
Orthopedics-MS CP MD, Sim. Reb. Imp.	37.6	1005	0.2	10	28.5	889	27.9	870	30-39
Absence & Amputations (Maj./Min. members)							2.9	90	40-44
Mental (Psychotic)	7.7	205	5.0	257	9.0	280	5.0	156	50
Psychoneurotic									51
Personality disorders Alcoholism-Drug Addiction, Social Offenders									52
Mental Retardation			4.0	205	9.0	280	4.6	143	53
Neoplasms	2.2	58					9.4	293	60
Allergies-Endocrine-Nutritional-Metabolic	7.4	197			3.0	98			61
Blood-Vascular	13.5	361					1.0	31	62
Epilepsy-Neurological			10.0	514	2.8	87	2.5	78	63
Cardiac	16.0	428			14.4	449	18.6	580	64
Respiratory	5.6	149			9.5	296	7.4	230	65
Digestive	9.7	259			3.0	93	3.1	96	66
Genito-Urinary	5.0	133					2.4	74	67
Speech Impairment			5.0	257			0.7	21	68
Not elsewhere Classified (NEC)							4.1	127	69

INCIDENCE OF BLINDNESS BY COUNTY IN REGION I

(Based on 2 Per Thousand Population)

County	Total	Under 20	20-30	30-40	40-50	50-60	60-over
Defiance	79	19	10	11	11	10	12
Erie	154	37	20	22	22	21	25
Fulton	63	15	8	9	10	9	11
Hancock	119	28	16	17	17	16	18
Henry	54	14	8	8	8	7	9
Huron	102	24	14	15	15	14	16
Lucas	931	215	131	139	140	130	141
Ottawa	76	21	13	9	12	9	14
Sandusky	122	29	17	19	18	17	19
Seneca	124	29	17	19	18	17	19
Williams	(no figures)						
Wood	160	37	22	24	24	23	25
Wyandot	45	11	6	7	7	6	8
TOTAL	2,029	479	280	299	302	279	317

Joseph L. Sullivan (Region I, Ohio Bureau of Services for the Blind)
6/26/67

APPENDIX B

Task Force on Mental Disabilities

Page

1. Mental Disabilities Task Force Resource Material 107

2. Incidence of Mental Retardation 108-109

MENTAL DISABILITIES TASK FORCE

RESOURCE MATERIAL

Annual Report, 1965-1966, Ohio Department of Mental Hygiene and Correction

Comprehensive Community Mental Health Planning, 1963-1965, The State of Ohio.

Hirschfeld, A. H. and Behan, R. C., The Accident Process, I, II, III, Journal of AMA, 1963.

Lucas County Community Health Study, Vol. II, 1965, Toledo Council of Social Agencies.

Mental Retardation Blueprint for action, 1965, The Greater Cleveland Mental Retardation Planning Project.

Ohio State Construction Plans for Mental Health Centers and Mental Retardation Facilities, 1965, Ohio Department of Mental Hygiene and Correction.

Profile of the Community, Lucas County Health Study-Part I, The Study area and Selected Characteristics of the People who Live There, May 1964.

Rehabilitation and Restoration of the Mentally and Emotionally Handicapped, Final Report of the Executive Subcommittee on Rehabilitation and Restoration, 1965.

Report of Citizens' Committee of Ohio Planning Region IX, Comprehensive Mental Health and Mental Retardation Planning Project, 1963-1965.

State of Ohio Construction Plan for Mental Health Facilities 1966-1967, Ohio Department of Mental Hygiene and Correction.

Estimate of Number of Mentally Retarded Persons in Ohio by Selected Age Groups, by Degrees of Retardation, 1960 and 1970

	Total Population	Under 6 Years	6 to 21 Years	21 Years and Over
1960				
Total population	9,706,397	1,360,729	2,506,357	5,839,311
Retarded population	153,995	20,411	75,191	58,393
Mild or educable	105,463	13,607	62,659	29,197
Moderate or trainable	38,825	5,443	10,025	23,357
Severe or Dependent	9,707	1,361	2,507	5,839
1970				
Total Population	11,510,200	1,613,700	2,971,900	6,924,600
Retarded population	182,609	24,206	89,157	69,246
Mild or educable	125,057	16,137	74,297	34,623
Moderate or trainable	46,041	6,455	11,888	27,698
Severe or dependent	11,511	1,614	2,972	6,925

Estimated Retarded Population by Age Range, within General Population

Chronological Age Range	Estimated Percent of General Population Retarded According to Degree of Retardation		
	Mild [1]	Moderate [2]	Severe and Profound [3]
0 - 6 Years	1.0%	.4%	.1%
6 - 12 Years	2.5%	.4%	.1%
21 + Years	0.5%	.4%	.1%

For general description only:

1 Intelligence Quotient Range (Approx.) 50-70 (-80 Effective 1967)
2 Intelligence Quotient Range (Approx.) 35-50
3 Intelligence Quotient Range (Approx) 0-35
(Severely: 20-25) (Profoundly: 20 or less)

③

Estimate of Number of Mentally Retarded Persons in Region I by Selected Age Groups, by Degrees of Retardation: 1965, 1970, 1975 and 1980.

	Total Population	Under 6 Years	6 to 21 Years	21 Years and Over
1965 Population	1,111,178	155,676	286,684	668,374
Retarded Population	17,556	2,500	4,515	10,541
Mild or Educable	12,000	1,680	3,100	7,220
Moderate or Trainable	4,434	628	1,144	2,662
Severe or Dependent	1,111	157	279	675
1970 Population	1,197,453	167,763	308,943	720,376
Retarded Population	18,920	2,651	4,882	11,387
Mild or Educable	12,933	1,812	3,337	7,784
Moderate or trainable	4,778	669	1,234	2,875
Severe or Dependent	1,197	168	309	720
1975 Population	1,283,728	179,850	331,202	772,278
Retarded Population	20,283	2,842	5,233	12,208
Mild or Educable	13,864	1,942	3,578	8,344
Moderate or Trainable	5,122	718	1,322	3,082
Severe or Dependent	1,284	181	331	772
1980 Population	1,370,002	191,937	353,461	824,180
Retarded Population	21,646	3,036	5,585	13,025
Mild or Educable	14,796	2,075	3,817	8,904
Moderate or Trainable	5,466	766	1,411	3,289
Severe or Dependent	1,370	192	354	824

APPENDIX C

TASK FORCE ON SOCIAL DISABILITIES

Page

1. Task Force Questionnaire 113
2. Results of Questionnaire by Probationers 114
3. Results of Questionnaire by Parolees 115
4. Inmates in Ohio Adult Correction Institutions, By Institutions, by County 116

Dear

You have been chosen to participate in a State Wide Planning program in the area of social disability.

We feel that you have something positive to offer to any new plan of rehabilitation. Please think these questions over carefully and give your own opinion. There is no need to confer with another person and the questionnaire should not take more than ten minutes.

1. What is the biggest obstacle to your own successful adjustment?

2. What do you think should be done to assist men on parole?

3. Which period of parole do you think is the most critical (toughest) for the parolee or probationer?

   (a) Within the first 3 months?

   (b) Within the second 3 months?

   (c) During last 6 months?

4.-5. Who is the most important person in the life of the parolee? (For example: Wife, Mother, Father, Minister, Parole Officer, Welfare Worker, Close Friend, Other?) ____________________

Why is this person important to you?

6. Is this your first - arrest/s?

second -

third -

fourth or more -

Thank you. You have made a valuable contribution to our study.

James A. Smith
Chairman
Task Force on the Public Offender

RESULTS OF QUESTIONNAIRE

By Probationers

BIGGEST OBSTACLE TO SUCCESSFUL ADJUSTMENT		WHAT SHOULD BE DONE TO ASSIST MEN ON PROBATION		CRITICAL PERIOD OF PROBATION		MOST IMPORTANT PERSON IN PROBATIONER'S LIFE		NUMBER OF ARRESTS	
A. Family	4	A. Finding jobs	8	A. 1st. 3 mos	18	A. Probation officer	13	A. 1st.	10
B. Employment	8	B. Guidance	13	B. 2nd. 3 mos	6	B. Family	15	B. 2nd.	3
C. Personal Adjustment	12	C. No answer	12	C. last 6 mos	8	C. Friends	4	C. 3rd.	10
D. No Answer	9			D. No answer	1	D. No answer	1	D. 4th +	7
								E. No ans	2

Out of the 50 people taking this survey, 33 responded; all were male.

RESULTS OF QUESTIONNAIRE

by Parolees

BIGGEST OBSTACLE TO SUCCESSFUL ADJUSTMENT		WHAT SHOULD BE DONE TO ASSIST MEN OF PAROLE		CRITICAL PERIOD OF PROBATION		MOST IMPORTANT PERSON IN PROBATIONER'S LIFE		NUMBER OF ARRESTS	
MEN									
A. Friends	3	A. Finding jobs	19	A. 1st 3 mos	25	A. Parole Officer	13	A. first	6
B. Family	5	B. Guidance	7	B. 2nd 3 mos	4	B. Family	10	B. second	9
C. Employment	8	C. Training	1	C. last 6 mos	6	C. Friends	4	C. third +	4
D. Social acceptance	6	D. No answer	4	D. All parole	2	D. no answer	0	D. four or more	10
E. Personal Adjustment	3			E. No answer	0				
F. Maintaining good health	2								
G. No answer	3								
WOMEN									
A. Friends	4	A. Jobs	5	A. 1st 3 mos	7	A. Parole Officer	5	A. 1st	6
B. Social Acceptance	3	B. Guidance	1	B. 2nd 3 mos	0	B. Family	3*	B. 2nd	1
C. No answer	1	C. Training	1	C. last 6 mos	1	C. Friends	2	C. 3rd	0
		D. No answer						D. four +	1

(*overlap in answer)

Out of the 50 people taking the survey, 37 returned the questionnaire; 29 men, 8 women

INMATES IN OHIO ADULT CORRECTION INSTITUTIONS,

BY INSTITUTION, BY COUNTY

June 30, 1964

TOTAL 11,785

(Region I only)

County	Total	Ohio State Reform.	Ohio Reform. Women	London Corr. Ins.	Ohio Penitentiary	Marion Correct. Ins.	Lebanon Correct. Ins.
Defiance	25	7	-	4	10	2	2
Erie	81	20	3	6	33	18	1
Fulton	9	4	-	-	3	2	-
Hancock	29	11	-	3	11	4	-
Henry	18	3	1	5	7	2	-
Huron	27	8	-	2	8	7	2
Lucas	751	215	30	79	249	168	10
Ottawa	15	1	1	1	6	6	-
Sandusky	43	10	-	8	16	8	1
Seneca	21	4	-	5	7	4	1
Williams	13	7	-	-	5	1	-
Wood	51	20	3	4	12	11	1
Wyandot	6	-	-	1	5	-	-

Material taken from Ohio Department of Corrections

APPENDIX D

TASK FORCE ON MANPOWER

Page

1. Task Force Questionnaire 119-121
2. Results of Questionnaire 122-124
3. Location of Resources Inventoried 125

QUESTIONNAIRE

Governor's Council on Vocational Rehabilitation
Comprehensive Statewide Planning
Task Force on Manpower
Samuel S. Long, Chairman

Positions	Total positions filled*	Budgeted but unfilled	Estimated additional need 1970	Salary range
Administrative				
Medical Director				
Physician				
Psychologist				
Registered Nurse				
Rehabilitation Nurse				
Psycometrist				
Occupational Therapist				
Physical Therapist				
Audiologist				
Speech Therapist				
Communications Instructor				
Mobility Instructor				
Home Teacher				
Placement Counselor				
Group Social Worker				
Social Case Worker				
Medical Social Worker				
Vocational Evaluator				
Vocational Counselor				
Vocational Teacher				
Prosthetist				
Orthotist				
Workshop Foreman				
Licensed Practical Nurse				
Therapy Aide				
Nurses Aide				
Orderly				
Volunteers				
Non-Patient Service				
Other (Please Specify)				

* Give full-time equivalent if part-time employees are included.

1. Do you have plans for expanding your existing services or providing additional services between now and 1970? If yes, please give a brief summary of your plans.

   If yes to above, what additional personnel do you feel you will need with your expanded programs? (Specify)

2. Do you see any particular areas of anticipated shortages in professional personnel in the next few years?

3. Do you offer any staff development facilities or programs?

4. Where do you send your staff for additional training if you have no such program?

5. Do you see any specific areas where there is a need for training programs?

6. Do you feel that existing educational programs will train sufficient numbers of personnel for future program demands?

7. What are your principle sources of professional personnel for your institution?

8. Please give job descriptions for budgeted positions in instances where they are not self-explanatory.

Name ____________________________
Agency ____________________________
Address ____________________________
Town ____________________________

Please return the questionnaire to

Hospital Planning Association
2243 Ashland Avenue
Toledo, Ohio 43620

6/15/67

RESOURCE	TYPE	Will you be expanding your Services in the future		Do you offer Staff Development Programs		Will Existing Educational Programs Train an Adequate # of Pros.	
		YES	NO	YES	NO	YES	NO
1	H	X			X		X
2	H		X	X			X
3	H	X		X			X
4	H	X		X			X
5	H	X		X			X
6	H		X		X	X	
7	H	X		X			X
8	H		X				X
9	H	X		X		X	
10	H	X		X			X
11	H	X		X			X
12	H	X		X			X
13	H		X		X		X
14	F	X		X			X
15	F	X			X		X
16	F	X		X			X
17	A	X		X			X
18	F	X			X		X
19	A	X		X		X	
20	F	X			X	X	
21	F	X		X			X
22	F		X		X	X	
23	F	X			X		X
24	F	X		X			X
25	F	X			X		X
26	F		X		X	X	
27	A	X			X	X	
28	F	X			X		X
29	F	X			X		X
30	F	X		X			X
TOTAL		24	6	16	13	7	23

Key: H - Hospital
F - Facility
A - Agency

Position	Positions budgeted, but unfilled - all agencies	Estimated number of professionals needed by 1970 -- all agencies	Number of AGENCIES declaring need because of their expansions	Number of AGENCIES indicating a shortage of specific personnel	Number of AGENCIES indicating need for training programs for specific personnel	Number of AGENCIES having budgeted vacancies	Number of AGENCIES indicating an estimated need for personnel
Administrative	5	13	2	1	0	4	7
Medical Director	1	3	1	1	0	1	3
Physician	4	11	3	2	0	3	3
Psychologist	2	8	4	5	2	2	5
Registered Nurse	37	132	8	6	4	3	8
Rehabilitation Nurse	0	8	1	0	3	0	4
Psycometrist	0	1	2	1	0	0	1
Occupational Therapist	2	11	4	5	0	2	7
Physical Therapist	1	13	5	6	2	1	9
Audiologist	1	1	0	0	0	1	2
Speech Therapist	1	5	5	1	2	1	4
Communications Instructor	0	0	1	0	1	0	0
Mobility Instructor	0	0	0	0	0	0	0
Home Teacher	0	3	1	0	1	0	3
Placement Counselor	0	5	2	0	0	0	3
Group Social Worker	1	8	2	0	0	1	4
Social Case Worker	5	24	10	7	2	5	11
Medical Social Worker	2	10	0	2	1	2	6
Vocational Evaluator	3	13	1	2	1	2	6
Vocational Counselor	6	9	3	1	1	2	4
Vocational Teacher	3	17	3	0	1	2	6
Prosthetist	0	1	0	0	1	0	1
Orthotist	0	10	0	0	1	0	2
Workshop Foreman	0	13	0	1	0	0	2
Licensed Practical Nurse	36	105	4	0	2	4	6
Therapy Aide	4	21	1	0	1	1	7
Nurses Aide	6	97	4	0	1	1	6
Orderly	13	131	1	0	0	2	7
Volunteers	100	282	0	0	0	1	3
Other Psychiatrist	0	0	1	1	0	0	0
Non-patient Service	0	0	0	0	0	0	0
Radiation Therapist	0	0	1	0	0	0	0
X-Ray Technician	0	0	0	3	0	0	0
Med. Technology	0	0	0	1	0	0	0
Lab. Technology	0	0	0	3	0	0	0
Recreation	2	2	3	2	1	1	1
Special Ed. Teacher	4	2	2	1	0	1	1

Question #4: Where do you send your staff for additional training if you have no such program?

	Number of Agencies
No response	8
Special seminars and institutes	11
O.S.U.	3
Other Ohio Universities	3
Other Universities	6
Facilities and Hospitals	5
Agency staff development	3
No specific resource	1

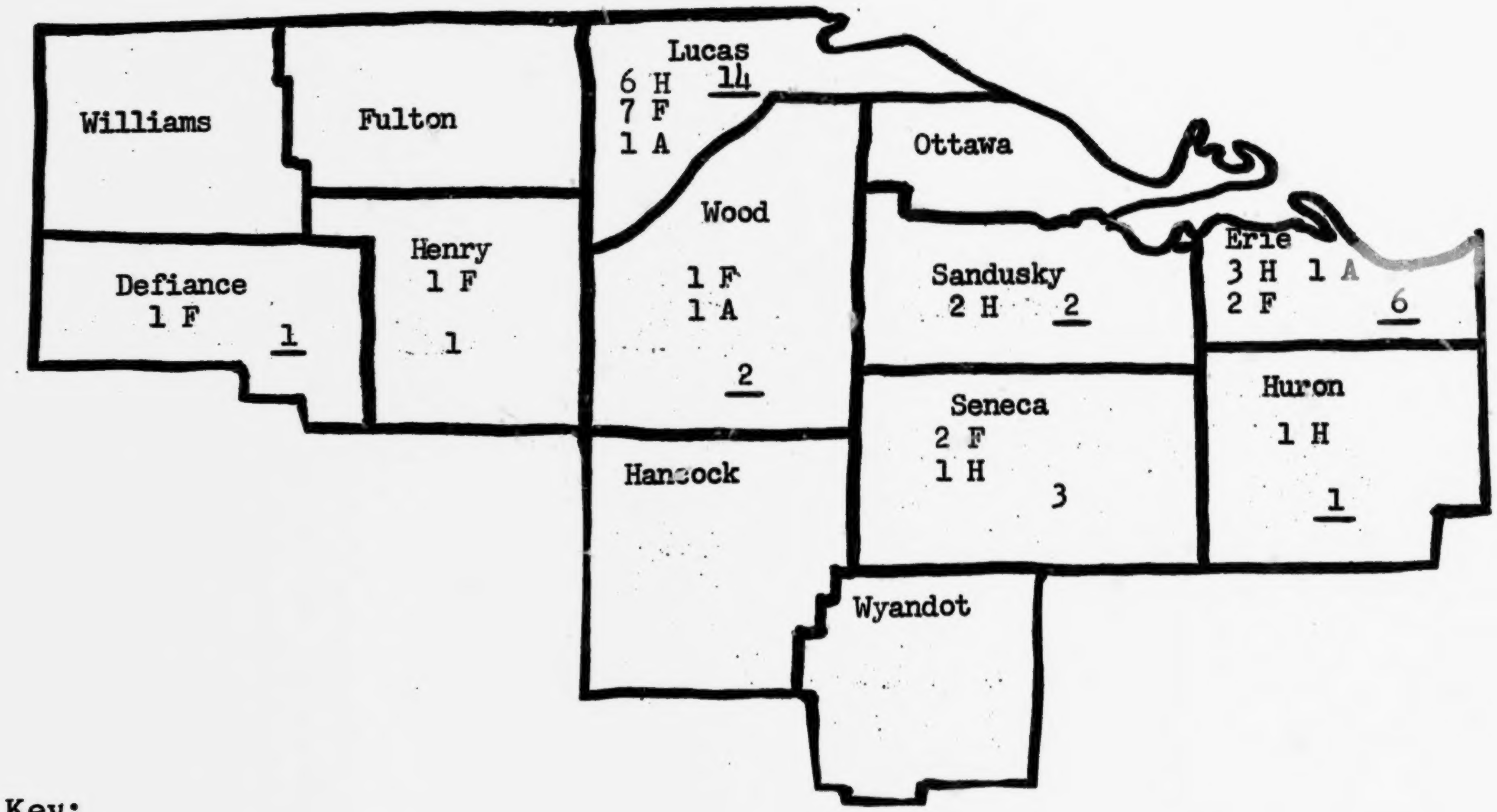
Question # 7: What are your principal sources of professional personnel for your institution?

No Response	5
O.S.U.	2
Other Universities	8
Schools of Nursing	2
Through professional journals and associations	14
Facilities and hospitals	3
Informal: friends, walk-ins, & referrals	5
No specific resource	2

LOCATION OF RESOURCES

INVENTORIED

TOTAL = 30


Williams
Fulton
Lucas
6 H
7 F
1 A
14
Ottawa
Wood
1 F
1 A
2
Defiance
1 F
1
Henry
1 F
1
Sandusky
2 H
2
Erie
3 H 1 A
2 F
6
Seneca
2 F
1 H
3
Huron
1 H
1
Hancock
Wyandot

Key:

H - Hospital
F - Facility (non-hospital)
A - Agency

APPENDIX E

TASK FORCE ON INTER-AGENCY COORDINATION

Page

1. Task Force Letter Accompanying Questionnaire 129

2. Task Force Questionnaire 130-131

Governor James Rhodes has organized the Governor's Council on Vocational Rehabilitation in the State of Ohio to survey the number and needs of its handicapped.

We in Northwestern Ohio are in Region I, encompassing thirteen (13) counties. We are in the process of putting together a Directory of Services to be made available to the handicapped and would like your assistance. Our definition of rehabilitation agencies is "those that include professional help serving the physically, mentally and socially disabled."

In your community we list the following agencies to whom we have already sent a questionnaire.

____

____

____

If there are any others that we have omitted, would you please either fill in the accompanying sheets or distribute them and have them filled out and mailed back to the

Vocational Rehabilitation Office
510 Gardner Building
Toledo, Ohio 43604
Attention of: Douglas Burleigh

Sincerely yours,

Chris P. Regas
CO-CHAIRMAN
Task Force on Inter-Agency Coordination

COMPREHENSIVE AGENCY REHABILITATION SERVICES QUESTIONNAIRE

DATE:________________

NAME OF AGENCY____

ADDRESS:______________________________ PHONE________________

NAME OF DIRECTOR:________________________

1. DESCRIPTION OF SERVICES: (Types and kinds - give name of contact person for each service and/or referral)

2. ELIGIBILITY REQUIREMENTS: (Sex, age limit, etc.)

3. FEE POLICY:

4. PREFERRED METHOD OF REFERRAL: (Method of contact, etc.)

5. REFERRAL INFORMATION DESIRED REGARDING CLIENT:

6. DETAILED AND SPECIFIC INFORMATION REGARDING UNUSUAL SERVICES:

7. EXTENT OF REFERRALS TO OTHER AGENCIES:

APPENDIX F

TASK FORCE ON FACILITIES AND WORKSHOPS

Page

1. Population, incidence of disability, number of rehabilitations and number of Facilities and Workshops by County, in Region I 135

2. Geographic Location of Facilities and Workshops in Region I 136

3. Sponsorship and Sponsor Property Interest in Facilities and Workshops in Region I, by County 137

4. Primary Disability groups served during 1966 in Facilities and Workshops in Region I, by County 138

5. Services by category and county offered in Facilities and Workshops in Region I 139

6. Total clients served, BVR clients referred, daily rehabilitation and sheltered workshop services rendered; service capacity of facility and workshop indicating those refused services due to limited capacity, by County, in Region I 140

7. Present personnel employed in Facilities and Workshops in Region I, by specialization and by County 141

8. Survey of Facilities and Workshops in Region I 142-147

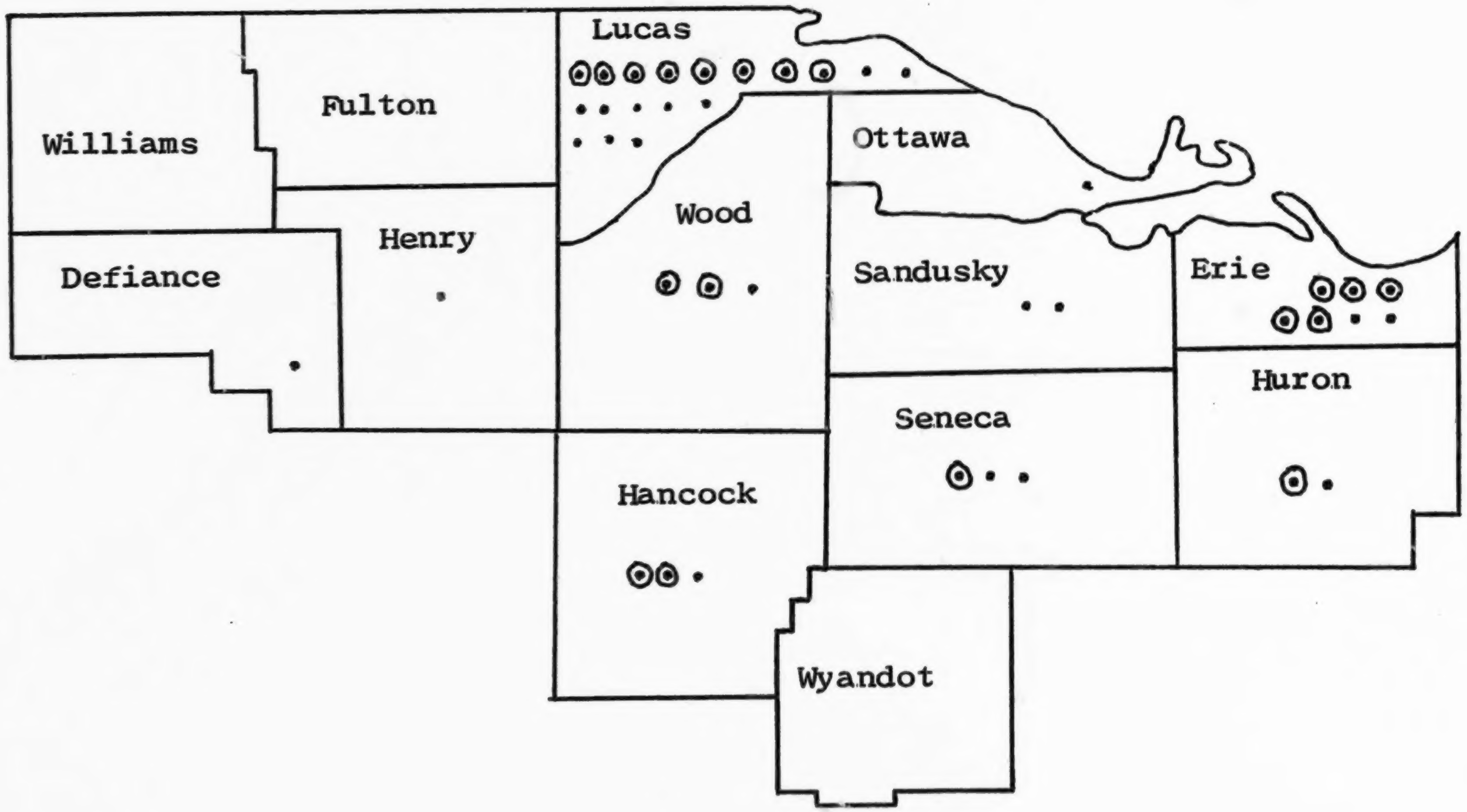
9. Survey of future needs of Facilities and Workshops in Region I 148-149

10. Information regarding long range planning of agencies in Region I 150-152

Population, incidence of disability, number of rehabilitations and number of Facilities and Workshops, by County, in Region I

	Population	Incidence of Disability	BVR Rehabilitations	Number of Facilities: Reporting	Number of Facilities: Yet to Report	Number of Facilities: Total
Defiance	34,750	4,681	7	0	1	1
Erie	76,876	10,363	18	5	2	7
Fulton	31,051	4,179	12	0	0	0
Hancock	59,145	7,973	18	2	1	3
Henry	27,016	3,638	5	0	1	1
Huron	51,358	6,923	24	1	1	2
Lucas	465,209	65,439	188	23	20	43
Ottawa	38,007	5,122	8	0	1	1
Sandusky	61,476	8,287	18	2	0	2
Seneca	62,111	8,370	41	3	0	3
Williams	31,933	4,303	10	0	0	0
Wood	80,030	10,788	17	2	1	3
Wyandot	22,293	3,000	8	0	0	0
Total	1,061,284	143,066	373	38	28	66

Geographic Location of Facilities and Workshops in Region I


Lucas
Fulton
Williams
Ottawa
Wood
Henry
Defiance
Sandusky
Erie
Huron
Seneca
Hancock
Wyandot

• Identified Facilities & Workshops as of 6/26/67

⊙ Inventory Completed as of 6/26/67

Sponsorship and Sponsor Property Interest in Facilities and Workshops in Region I by County

	County													
Sponsorship	Total	Defiance	Erie	Fulton	Hancock	Henry	Huron	Lucas	Ottawa	Sandusky	Seneca	Williams	Wood	Wyandot
A. City	1				1									
B. County	6				2		1	1			1		1	
C. State-vocational rehabilitation agency	1												1	
D. Other state (example-State Crippled Children Societies, etc.)	4						1	1					2	
E. Other public	2										1		1	
F. Community non-profit assoc. (example-United Appeal, Health Fund, etc.)	10		3		1			4			1		1	
G. Church affiliated	2		1					1						
H. Other non-profit	7		4					3						
Totals	33		8		4		2	10			3		6	
Sponsor Interest in Property														
A. Own	13		4					7			1		1	
B. Rent or lease	5		1		1		1	1					1	
C. Rent free	1				1									
Totals	19		5		2		1	8			1		2	

Primary disability groups served during 1966 in Facilities and Workshops in Region I, by County

Disability Groups	County													
	Total	Defiance	Erie	Fulton	Hancock	Henry	Huron	Lucas	Ottawa	Sandusky	Seneca	Williams	Wood	Wyandot
A. Visual Impairments	4		2					2						
B. Hearing Impairments	7		2					3			1		1	
C. Orthopedic Deformity or Functional Impairment, except amputations (example-cerebral palsy, muscular dystrophy, polio, etc.)	11		4		1			4			1		1	
D. Absence or amputation of upper or lower extremities	8		4		1			2					1	
E. Mental, psychoneurotic and personality disorders (example-alcoholism, psychotic disorders, drug addiction, etc.)	10		3		1		1	5						
F. Any other disabling conditions (explain)	8		1		1			3			1		2	
Totals	48		16		4		1	19			3		5	

Services by category and County offered in Facilities and Workshops in Region I

Services	Total	Defiance	Erie	Fulton	Hancock	Henry	Huron	Lucas	Ottawa	Sandusky	Seneca	Williams	Wood	Wyandot
A. Physical & medical evaluation	6		2					3			1			
B. Medical management	4		1					3						
C. Physical therapy	7		3		1			2			1			
D. Occupational therapy and/or activities of daily living	5							4			1			
E. Speech & hearing services	3							1			1		1	
F. Medical consultation	6		1		1			3			1			
G. Psychological services, diagnostic and/or treatment	7		1				1	3			1		1	
H. Social services	7		1				1	5						
I. Vocational evaluation	6		1					5						
J. Pre-vocational and/or vocational training	6		1					4					1	
K. Vocational counseling--rehabilitation counseling	7		2					4					1	
L. Personal adjustment training, including mobility	7		1					4			1		1	
M. Job conditioning	8		2					5					1	
N. Job placement	8		2					5					1	
O. Extended employment	7		2					5						
P. Transitional employment	6		2					3					1	
Q. Other	1						1							
Totals	101		22		2		3	59			7		8	

Total clients served, BVR clients referred, daily rehabilitation and sheltered workshop services rendered; service capacity of facility and workshop indicating those refused services due to limited capacity, by County, in Region I.

ITEM	County													
	Total	Defiance	Erie	Fulton	Hancock	Henry	Huron	Lucas	Ottawa	Sandusky	Seneca	Williams	Wood	Wyandot
8.1 Total Clients served	19,398		5062		6422		651	6681		124	287		171	
8.2 BVR Clients referred	481		2		6		3	451		5	29		5	
8.3 Daily Rehabilitation service			38		24		11	1152		29	50		32	
Daily Sheltered Workshop service			48		16			1376					12	
Total Daily Service	2,788		86		40		11	2528		29	50		44	
8.4 Capacity of Rehabilitation Service			43		40		11	742			80		32	
Capacity of Workshop Service			105		16			1066					12	
Total Capacity	2,147		148		56		11	1808			80		44	
8.5 Refused Rehab. Services								106					15	
Refused Workshop Services			21					1099					9	
Total Refused	1,250		21					1205					24	
8.6 Number Reporting	21	0	5	0	2	0	1	9	0	1	1	0	2	0
Number to Report	21	1	2	0	1	1	1	9	1	1	3	0	1	0

Present personnel employed in Facilities and Workshops in Region I, by specialization and by County.

Personnel	Total	Defiance	Erie	Fulton	Hancock	Henry	Huron	Lucas	Ottawa	Sandusky	Seneca	Williams	Wood	Wyandot
		County												
Medical	33		1		1		1	29		1				
Psychologist	12		1		1			9			1			
Psychologist Trainee	1				1									
Physical Therapist	13		3		1			5		2	2			
Physical Therapist Asst./Aid	12		2		2		4			4				
Social Service Worker	18						1	16		1				
Occupational Therapist	30							29			1			
Vocational Counselor	14							14						
Nurse/Student	72		1					54		17				
Director (adm), Business Manager	13		2					9			1		1	
Teacher	2							2						
Speech & Hearing	15							1		1	2		11	
Workshop Supervisor	8		1					7						
Recreational Therapist	1							1						
Masseur	1							1						
Totals	245		11		6		6	177		26	7		12	
Number Reporting	21	0	5	0	2	0	1	9	0	1	1	0	2	0
Number to Report	21	1	2	0	1	1	1	9	1	1	3	0	1	0

From: Betty Jane Memorial Rehabilitation Center
65 St Francis Avenue
Tiffin, Ohio

QUESTIONNAIRE

A. Resources for meeting needs - What are the current resources for providing rehabilitation services in your county? A list of the topics to be covered in this questionnaire of operating programs is suggested below; please underline those available within your county and add any additional ones.

1. Agencies - Bureau of Vocational Rehabilitation Office, Veterans Administration, Public Welfare, City Health Unit, County Health Unit, District Health Unit, Easter Seal Society, United Cerebral Palsy, Association for Retarded Children, Mental Health, National Foundation (March of Dimes), Heart Association, American Red Cross.

   Others:

2. Services Provided -
   a. Medical, psychiatric and psychological examinations.
   b. Vocational diagnosis, including study of the interests, abilities and aptitudes of the individual, based on social and personal history, education and work experiences.
   c. Individual counseling and guidance to determine the services required to enable the individual to select a suitable field of work, and to develop a program of services needed to attain the employment objectives.
   d. Hospitalization, medical, surgical and psychiatric services needed to correct or modify a disability which is a substantial handicap to employment.
   e. Prosthetic appliances, such as limbs, hearing aids, trusses, braces, glasses, wheelchairs.
   f. Physical therapy, occupational therapy, speech & hearing therapy.

2. Continued, Services Provided -

   g. Personal adjustment training to meet the needs of daily living such as travel to and from work.

   h. Job training, in schools or colleges, in sheltered workshops, in-the-plant, by tutor or via correspondence.

   i. Maintenance and transportation during training and treatment.

   j. Training supplies, occupational tools, equipment and licenses, as needed.

   k. Placement, including establishment in own business.

   l. Follow-up placement, to insure adjustment to job.

   m. Sheltered workshops for one or more handicapped types.

   n. Classes for mentally retarded below 50 I.Q.

   o. Classes for "slow learners", I.Q., 50 to 75.

3. Area - How many square miles in County _______________.

   Population of county _________________________.

   Staff - How many full time persons are responsible for rehabilitation in the county __________?

   Do all agencies cooperate in providing services? ___(yes)___(NO)

B. Principal problems.

The rehabilitation of persons with handicaps presents special problems not encountered in working with other persons. These merit examination in the light of the experience of agencies with operating programs. Some of the principle problems are listed below;

1. What are the general attitudes of the disabled person toward employment, self-support, independent living?

From: Betty Jane Center
Questionnaire

B. (cont.) Principal problems

2. What are the employer policies concerning age limits in hiring and what are the physical requirements?

3. How do vocational counselors feel towards working with age groups?

4. What are the county facilities for retaining disabled persons?

5. What are the placement opportunities for handicapped workers?

6. What is the work tolerance in terms of health of handicapped workers?

7. Can you estimate the average educational and work experience background of handicapped workers within the county?

8. Are there transportation difficulties?

C. Questions for exploration, discussion and identification of needs within the County.

1. What do you see as the principal unmet needs of handicapped persons in the field of rehabilitation?

2. Is size of state and county professional staff a limitation on the availability of services to handicapped workers?
   Due to lack of funds?
   Limitations in supply of specialists and facilities?
   Other:

From: Betty Jane Center
Questionnaire

C. (cont.) Questions for exploration, discussion, etc.

3. Are the agencies making use of the best technical procedures for evaluation of the disabled?

4. Is there a need for additional training, tryout and evaluation facilities for rehabilitees? ________________.

5. Is there a need for additional placement opportunities, in government ________, in private industry_________, sheltered workshops ________?

6. How adequate are the agencies' public education program? Are they reaching the groups in the community who ought to know about the rehabilitation program - employers, unions, schools, etc.?

7. Do you have any knowledge of any non-working physical therapists, occupational therapists, public health nurses, speech therapists, social workers, psychologists or home economists within your community?

8. Do you have any physical education (coaches, etc.) specialists that have had any training in work with the handicapped?

NAME ______________________________
AGENCY ____________________________
ADDRESS ___________________________
TOWN ______________________________

In the area of Northwestern Ohio there is an appalling lack of public education and communication between official agencies. The various official and voluntary agencies appear to be very jealous of their identity; however, when the chips are down, they do cooperate for the client. We feel that this area like most areas, could be better served if there were true cooperation between agencies and referral sources.

In the areas where there is a knowledge of the Bureau of Vocational Rehabilitation, this appears to be to the people a "cure-all" for their problems, and they are not knowledgeable enough about the rules and regulations of the Bureau of Vocational Rehabilitation to know that they cannot always step in when asked and do the job requested.

We have found very little knowledge of the Governor's Committee of Employing the Handicapped and very few employers are willing to hire handicapped persons, however, upon explaining the problems, training, and what can be expected, most of the ones contacted would give it a try if a person were evaluated, trained and placed when the opening occurred.

Classes for the multiple handicapped children are almost non-existent throughout the whole area and most of the areas believe that the problems with the mentally retarded can be solved just by putting him in a sheltered workshop even though they are not quite sure what a sheltered workshop is or does.

We have found that the physician is lethargic in wanting to refer patients to the Bureau of Vocational Rehabilitation because, "I referred a patient to them one time that I thought they should do something for and they didn't, so I won't send anybody to them again." They should be informed of the problems with the Bureau of Vocational Rehabilitation, rules, regulations and the types of clients that can be helped by this agency.

We have found school administrators that did not want to be interferred with by the Bureau of Vocational Rehabilitation, many of them thinking that it was the department of education trying to tell them what to do for their job. They seemed to be very jealous of outside "interference." However, when confronted with the direct question, "What does the Bureau of Vocational Rehabilitation do, what have they done that would make you not want to cooperate", the questions cannot be answered. Many school administrators answer questions that they do not believe they have any handicapped children in the community that are not being cared for because they do not have any in school.

Transportation seems to be the greatest problem and getting people from these rural and urban areas into Centers where they can be diagnosed and treated and placed in employment.

There are few and rare institutions where dormitory care can be given during rehabilitation and many organizations and agencies have ideas but no knowledge of how to combine their ideas with practical solutions for their particular area.

From questions asked and answers received, this writer feels that unless you are from a poverty situation, on the welfare rolls, mentally retarded, blind, live in the heart of a downtown metropolitan area, you do not stand a chance of rehabilitation because if you become vocationally handicapped in most areas, case finding for the referral is aimed at the aforementioned group. The so-called middle class person who needs vocational rehabilitation most when handicapped, is usually out on a limb because no agency is working with the family that would refer them to a Bureau of Vocational Rehabilitation agency for service.

Recommendations as a result of the survey are:

(1) That the Bureau of Vocational Rehabilitation should institute a public relations program over the State of Ohio with at least four regional offices so that schools, hospitals, doctors and other referring agencies with the community could learn what the Bureau of Vocational Rehabilitation does and how, and so that the general public would have a knowledge of the services available from this agency.

(2) That Northwestern Ohio be split into three areas of service for rehabilitation with the Centers being located at
  (a) Toledo which would serve Williams, Defiance, Fulton, Henry, Lucas, the northern one-half of Ottawa County, northern third of Wood County;
  (b) Lima which would serve Paulding, Van Wert, Mercer, Putnam, Allen, Auglaize and the western one-half of Hardin County;
  (c) Tiffin which would include Hancock, Wyandot, the western two-thirds of Crawford, Hardin, the western two-thirds of Erie County, Sandusky, the southern one-half of Ottawa County and the southern two-thirds of Wood County, plus Seneca County and Huron County.

There are facilities already in these communities and the referral habit has already been established. The facilities in these towns are developing full case finding evaluations, training and placement facilities. This would require quite a bit of coordination and effort and community cooperation but it could be done. These agencies then could also help with the public education programs in the areas of service. There should be some coordinated effort of service between the three areas of service and some coordination between the community served in these areas.

The Betty Jane Center stands ready to serve its responsibility in providing the services for the area mentioned and is attempting to develop evaluation, pre-vocational training, training and placement facilities as well as in residence facilities for the physical rehabilitation of people referred. If these three area centers could be officially sanctioned in some way, this would make the job easier to set up, coordinate and administer for the aid of the handicapped people in this part of Ohio.

Survey of Future Needs Of
Facilities and Workshops
in Region I

Expansion of Facilities Planned Between Now and 1975

Increase physical therapy services	63%
Increase occupational therapy services	63%
Increase speech therapy services	45%
Increase psychological services	45%
Increase social work services	72%
Make increases in other areas	45%
Increase in-patient facilities	63%

Of 63 per cent respondents who said they would increase their in-patient facilities also indicated that this would entail an additional 117,526 feet of space, 81 per cent of them saying that this would require new buildings and 36 per cent indicating remodeling as well. 54 per cent of the respondents indicated that they would accomplish this through the request for government grants, and 72 per cent through combinations or other sources of funds.

Planned New Areas

Planning new workshops	45%
Planning new evaluation units	63%
Planning dormitory facilities	27%
Planning new classroom facilities	54%
Planning other new areas	9%

Of those planning new areas, 63 per cent said that this would include new construction, 45 per cent indicated that this would be a remodeling job, and 27 per cent indicated that this would be on a rental or a lease agreement. The individuals who responded that there would be new planning and new construction for new areas, 63 per cent of them indicated that they hoped to accomplish this through federal grants, and 45 per cent of them said that they hoped to accomplish this through bond issues or other fund drives.

Of the twenty-four facilities and workshops contacted, sixteen responded. Of the sixteen that responded, three indicated that they planned no expansion in the near future. One indicated that their plans were not clear, and one indicated that rehabilitation services were offered through organization at another location, but that additional workshop facilities would be planned and developed.

Information Regarding Long-range Planning of Agencies in Region I*

Toledo

Board of Education - They hope to establish with cooperation of BVR a new work-study program to more nearly meet the needs of the potential high school drop out by possibly utilizing the old Toledo Post Office Building after remodeling--they're considering a third party funding project as well as a Section 2 establishment project for VR funding.

Sheltered Workshop for Mentally Retarded of Lucas County - they plan to expand their existing workshop by building a new addition and are considering writing a Section 2 establishment project to obtain VR funding.

Toledo Goodwill Industries - they plan to buy land and build a completely new building at the corner of Cherry and Huron streets and fund through a Section 12 construction grant which has already been approved by VRA.

Conlon Training Center - they hope to have a successful fund raising compaign in order to acquire the adjoining lot and expand their existing building, if successful in raising donor funds they will consider writing a Laird project to expand their workshop and employ more severely disabled.

Toledo Society for the Blind - they plan to establish a visual aids clinic at St. Vincent's Hospital and may consider a Section 4 expansion project for assistance in funding. They are also in the process of acquiring land behind the existing agency and when all the parcels are obtained they plan to renovate the present building and add additional new building and are considering funding this through a Laird project to VRA. Also, they plan to establish a mobility training section in their program and at present have the potential instructor in training in Arkansas we understand under the auspices of BSB.

---

*Information supplied by Mr. William Gregg, Coordinator, Workshops and Facilities, Bureau of Vocational Rehabilitation, Columbus, Ohio

Toledo Hospital - they have a building expansion program in progress now. We understand it is funded through Hill-Burton.

North Toledo Community House - they plan to remodel an existing idle building to establish a program to rehabilitate parolees and other disabled persons. They first plan to write a project development grant to study the need and develop justification and this could well lead to a Laird project for VRA funding at a later date.

Toledo State University - it has been reported that they plan to establish a rehabilitation component in a newly established medical college in the vicinity of Maumee Vallee Hospital. We have no information on method of funding.

Sandusky and Erie County

Goodwill Industries Branch - they plan to expand a program in newly leased space in the very near future and may have need for a workshop improvement project to fund additional equipment and additional supervisory positions.

Erie County Child Welfare Board - plans to establish a new workshop for mentally retarded in the new Betty Rinderle School of Erie County. The room for the workshop is already completed and we understand they are looking for workshop supervisors at the present time.

Good Samaritan Hospital - they plan to add an additional building for a mental health center and lease space to the Erie County Guidance Center who are presently in leased space in a downtown office building. This hospital also plans to build an intensive care unit. We do not know the method of funding.

Sandusky Memorial Hospital and Providence Hospital - have plans for pooling funds to build an extended care unit in the immediate neighborhood--they hope to earn Metropolitan Housing funds for this purpose.

Volunteers of America - they plan to start a funding campaign very soon to add a sizeable new building along the south side of their present building which will provide a new men's home and will include a new kitchen, dining room, dormitories, new offices, new chapel, and a public auditorium. In doing all this they would be able to expand their workshop operations if necessary in vacated space in the old building. They plan to do this with local funding.

Tiffin

Betty Jane Rehabilitation Center - under the new director, Mr. Pool, this agency has numerous plans for the immediate future, namely to develop an evaluation and personal adjustment center in the existing building by writing a Laird project for VRA funding; build an additional building onto the community classes building for mentally retarded and establish a sheltered workshop for all disability groups;

provide new and additional space to the Sandusky County Guidance Center which is on the Betty Jane property at present; and build onto their present building to establish classrooms and residence space for enlargement of the overall rehabilitation program. This long-range planning will probably involve several Laird projects.

Bowling Green and Wood County

Wood County Welfare Department and Department for Mental Retardation -- they have completed the writing of a project to study all of the Wood County needs for a sheltered workshop for all types of disabled persons and plan to fund this planning with a project development grant which has been requested and is presently waiting approval. This may well lead to a Section 2 establishment project at a later date.

Findlay

Blanchard Valley Hospital - has a huge building expansion program in progress now with 100% local funds. They were refused Hill-Burton funds because of low priority.

Training Center Blanchard Valley School - they plan to establish a sheltered workshop for mentally retarded in an existing new structure on the east side of town as soon as they can get more contracts from local industry and business. The new building is completed, the classes are in progress, the workshop is limping along at the present time. Is only considered a training area as they do not have workshop certification neither do they have work activity center certification. This agency seems to need further help and technical assistance for expansion.

Port Clinton and Ottawa County

Ottawa County Welfare Department - They may set up a workshop for mentally retarded in existing idle county children's home building. They may consider submitting a Section 2 establishment project for VRA funding.

Williams, Henry, Defiance, and Fulton Counties

Quad-Co, Inc. - they plan to remodel an existing building in Stryker, Ohio and add a new addition to establish a sheltered workshop for all disability groups and a work activity center for mentally retarded--they are completing the writing of a Section 2 estabishment project. Total dollar value being approximately $235,000.